# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for Ohio

## Application for 2013
## Annual Report for 2011

Document Generation Date: Friday, December 14, 2012

# Table of Contents

# I. General Requirements
## A. Letter of Transmittal
The Letter of Transmittal is to be provided as an attachment to this section.
***An attachment is included in this section. IA - Letter of Transmittal***

## B. Face Sheet
The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

## C. Assurances and Certifications
The assurance and certifications for Ohio can be made available by contacting

Karen Hughes, MPH, Chief
Division of Family and Community Health Services
Ohio Department of Health
246 North High Street
Columbus, OH 43215
(614) 466-3263

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## D. Table of Contents
This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

## E. Public Input
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The Ohio Department of Health made the FFY11 MCH BG application, including the Needs Assessment, available for public input through various traditional and non-traditional venues. The MCH BG application was placed on the ODH webpage, and the MCH BG Coordinator was listed as a point of contact for individuals wishing to send feedback directly to ODH. A link was placed on the ODH Webpage offering the public an opportunity to participate in a survey regarding the MCH BG application via Survey Monkey. Preliminary results from the survey are attached to the application. Notification of the webpage posting was sent to the MCH Advisory Committee and MCH Needs Assessment stakeholders. Stakeholders represented DFCHS grantees, other state agencies, local organizations, provider and professional groups and to some extent, parents/consumers.
With the rise of social media outlets such as Face Book and Twitter, for the first time the MCH BG was placed on the ODH Face Book Page, allowing anyone who has added ODH as a friend, a chance to review and provide input on the application. Placing a notice on the ODH Face Book Page serves as a way of reaching a broader population and hopefully receiving more consumer and family input. And finally, for all those individuals who follow ODH on Twitter, ODH was able

to "tweet" that the MCH BG is out for public input. The current application will be available on the ODH website at http://www.odh.ohio.gov/healthStats/data/needsassess/bgcommentsmain.aspx until the end of July.

Currently, ODH has received 22 responses from interested parties. Of those 22 responses 45% represents local Health Departments; 14% Parents/Parents of CSHCN; 13% WIC programs; 13% Community Health Center/Clinic; 9% Health Care Providers, and the remaining 6% represented various interested parties (e.g., University Faculty, Other State Agencies, Schools and other Community Based Organizations). Survey responders have provided ODH with feedback that will help inform how we move forward with activities related to the performance measures. The only concern that has been identified is related to National Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17. A provider asked that ODH include evidence-based programs that teach teens to avoid premarital sexual activity and other risk behaviors that contribute to teen pregnancy and evidence-based healthy relationship education to train FP nurses to provide prevention education of sexual coercion as part of our activities.

In response to this request ODH shared the following information with the provider and invited them to join our Action Learning Collaborative: Ohio was one of six (6) states selected in 2009 to participate in the Preconception Health and Adolescents Action Learning Collaborative sponsored by the Association of Maternal and Child Health programs (AMCHP), the Association of State and Territorial Health Officials (ASTHO) and the Centers for Disease Control and Prevention (CDC).

These states are working to integrate preconception health recommendations into their adolescent health efforts. Preconception health efforts are those strategies aimed at promoting the health and preventing disease among women, men and families in the period before a pregnancy occurs. The Action Learning collaborative (ALC) model brings together multidisciplinary teams for an 18-24 month period to analyze a problem in maternal and child health, identify resources, learn how to apply problem-solving techniques to that issue, review promising practices from other teams and create plans to address specific public health problems. Funding has been provided to support state teams through 2010.

Overall, the input received has been very positive, and ODH has received 9 letters of support for the FFY11 MCH BG application. Letters of support were sent by the following organizations:
1) Board of Health, Belmont County General Health District, St. Clairsville, Ohio
2) City of Cincinnati Health Department, Southwest Regional Resource Center, Cincinnati, Ohio
3) Clark County Combined Health District, Springfield, Ohio
4) Department of Public Health Division of Environment, Cleveland, Ohio
5) District Board of Health, Mahoning County Childhood Lead Poisoning Prevention Program, Youngstown, Ohio
6) Prevent Blindness Ohio, Columbus, Ohio
7) Toledo-Lucas County Health Department, Toledo, Ohio
8) Seneca County General Health District, Northwest Ohio Regional Resource Center, Tiffin, Ohio
9) Zanesville-Muskingham County Health Department, Zanesville, Ohio

Copies of the letters are kept on file in the DFCHS Office and are available upon request.

/2012/ The Ohio Department of Health (ODH) made the FFY12 MCH BG application, available for public input by placing an announcement on its ODH webpage. The webpage offered a variety of different options for those interested in reviewing all or parts of the application that might specifically appeal to them. The review documents were divided into sections based on three population groups.

A link was also placed on the ODH Webpage offering the public an opportunity to participate in a survey regarding the MCH BG application via Survey Monkey. Preliminary results from the survey are attached to the application. Notification of the webpage posting was sent to the MCH Advisory Committee and MCH Needs Assessment stakeholders. Stakeholders represented DFCHS grantees, other state agencies, local organizations, provider and professional groups and to some extent, parents/consumers.

ODH has received 45 responses from interested parties. Of those 45 responses 37% represents local Health Departments; 26% WIC programs; 10% represented various parties (e.g., Parent/Parents of CSHCN, Consumer of Health Care, Community Health Center/Clinic, and Advocacy Group); 9% State Health Department; 9 % Other State Agencies; 9% Health Care Providers. In our efforts to establish mechanisms for face to face feedback and input regarding; MCH programs, BG performance measures, indicators or other areas of interest to Title V, ODH was a major contributor in four town hall type meetings specifically for the purposes of soliciting input from the public. Those four major events are described below:

The BEACON (Best Evidence for Advancing Childhealth in Ohio NOW) Council hosted a Quality of Care Measurement Conference on February 8, 2011. ODH is a co-sponsor of the BEACON Council along with Ohio Department of Jobs and Family Services, Office of Ohio Health Plans (OHP). Governor Kasich's Office of Health Transformation presented Ohio's planned pursuit of quality improvement strategies to improve care delivery while reducing Ohio's Medicaid costs, other leading health care experts highlighted specific programmatic and cost reduction opportunities applicable to Ohio's Medicaid program. ODH highlighted MCH projects for children at risk for or with delayed development, autism, and social emotional concerns; the use of improvement science, to reduce preterm births and improve outcomes of preterm newborns as quickly as possible; and initiatives that address the pediatric obesity epidemic in Ohio. The conference's 85 participants included consumer advocates, physicians, representatives of children's hospitals, quality improvement professionals, other health care practitioners, representatives of private sector health plans, and leadership and staff from state government and health services agencies, including the Ohio Departments of Job and Family Services, Health, and Mental Health.

On March 11, 2011, a large group of stakeholders were brought together by ODH in a Home Visiting Stakeholder meeting for the purposes of creating a shared plan and vision for the MIECHVP Grant. Meeting participants were stakeholders interested in the Maternal, Infant and Early Childhood Home Visiting grant. Through a facilitated process ODH was able to create an opportunity for stakeholders to dialogue with HRSA representatives, reflect on how federal home visiting programs aligns with Ohio's early childhood systems; begin discussions on how Ohio could strengthen and improve programs under Title V, improve coordination of services for at risk communities, with a goal to identify and provide comprehensives services for families in at risk communities.

Project LAUNCH, a federal grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, to the Ohio Department of Health (ODH), is a comprehensive young child wellness initiative in Ohio. Its goal is to improve the health and wellness of children ages 0-8 and their families in Appalachian Ohio with a focus on the integration of health and mental health services, to improve local and state collaboration around policy and infrastructure improvements that support young child wellness in this region and statewide. ODH held a joint meeting of Project LAUNCH State and Local Council's on June 15, 2011 to facilitate the Council's creating a shared vision for Project LAUNCH that grows from an understanding of the communities the project serves and the local culture; and to identify ways for the state council to more fully support the work of the local council. Held in Logan Ohio, the state heard first-hand accounts about service priorities, from parents of children receiving services.

Feedback from each of these meetings was used to inform plans towards accomplishing the MCH BG Priorities. //2012//

***/2013/ The Ohio Department of Health (ODH) made the FFY13 MCH BG application, available for public input by placing an announcement on its ODH webpage, and conducting face to face meeting for the purposes of soliciting feedback and input. The response to this process is that the number of responders continues to increase. A full report outlining the process and feedback received is included as an attachment to the BG application. //2013//***

***An attachment is included in this section. IE - Public Input***

# II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

## C. Needs Assessment Summary

To facilitate on-going efforts to address the goals and priorities identified through the MCH BG Needs Assessment process Title V staff are working closely with the ODH team developing a State Health Assessment. In collaboration with its public health partners ODH has developed a 2011 State Health Assessment (SHA) plan which represents the first step in a multi-part process to identify and better address the population health needs of the state. The second step will involve the creation of a State Health Improvement Plan (SHIP), utilizing the SHA as well as other data sources, to identify and prioritize goals and objectives to help fulfill the public health system's mission to protect and improve the health of all Ohioans.

The health assessment includes 11 areas of focus addressing disease burden, including data on the leading causes of death in Ohio; the prevalence of certain chronic, communicable, and infectious diseases; unintentional and intentional injury rates; health behaviors, clinical risk factors, and recommended care; maternal and child health; health system access; and environmental health indicators. ODH will utilize information from the 2011 State Health Assessment to inform its next Strategic Planning process. The Title V program is engaged in the process and will closely monitor the goals and objectives that are identified for the MCH indicators in the plan. The indicators outlined in the SHA are directly related to the MCH priorities identified through the Needs Assessment process.

# III. State Overview
## A. Overview
Section III. A. Overview

As the flagship of Ohio's public health infrastructure, the Ohio Department of Health (ODH) works with 129 local health departments to promote its mission statement "to protect and improve the health of all Ohioans by preventing disease, promoting good health, and assuring access to quality health care". Ohio's Title V MCH Program embodies the states mission, and fully embraces the charge of improving healthcare for the populations it serves as exemplified by the nine priorities that have been selected. In addition Governor Strickland has set 12 priorities for the state of Ohio, and of those 12 the Title V MCH program aligns with 3; Health Care, Helping Ohio's Most Vulnerable, and Diversity.

ODH is a cabinet agency, and the director reports to the governor. ODH is organized by three program divisions and six offices. Program divisions are the Division of Family and Community Health Services, Division of Prevention and Division of Quality Assurance. The offices are Employee Services, Financial Affairs, Management Information Systems, General Counsel, Performance Improvement and Healthy Ohio, a Governor appointed Program housed at ODH. Healthy Ohio has three core program areas: health promotion, disease prevention and health equity. These areas work collaboratively with public and private partners and consult with the Healthy Ohio Advisory Council to create the changes in communities, worksites and schools that lead to better health for all Ohioans.

ODH has selected "Strengthen Program and Service Impact" as one of its strategic objectives that relates to the Maternal, Child, Health population. The key activities related to this objective are: a) determine health status improvement targets, b) identify key populations to target, c) use approaches which best demonstrated effectiveness, d) assure use of multiple and/or innovative approaches, e) define measures and apply effective evaluation. In achieving this objective MCH staff are encouraged to use the following filters; strengthen and expand key partnerships, use data to drive decision making, quality improvement and accountability, and use resources to eliminate health disparities and pursue health equity.

The health of Ohio, in comparison to other states, falls largely in the middle. Because of the size of the state and the demographics, Ohio does very well on some measures, and poorly on others. According to the United Health Foundation's America's Health Rankings, in 2009 Ohio ranked 33rd in the nation up from its ranking of 34 in 2008. Ohio continues to have a low rate of uninsured population and a high rate of high school graduation, but the prevalence of smoking and the percentage of children living in poverty have increased. Disparities in Ohio continue to persist. For example, the prevalence of low birth weight and the cardiovascular death rates are higher among non-Hispanic blacks than other races.

Demographics
The 2009 estimated population of Ohio was 11,542,645, giving the state a population density of 281.9 people per square mile. Ohio ranks as the seventh-most populous state among the 50 states and the District of Columbia. By 2030, Ohio is projected to remain the seventh-most populous state, with an estimated 12.3 million people. Between 2000 and 2030, the state expects to gain 254,616 people through migration. Females in Ohio accounted for 51.2 percent of the total population in 2008. Twenty-five to 64-year-olds make up 52.6 percent of the female population. Women age 65 years and over comprised 15.7 percent of the female population. Females 15-24 years of age make up 13.1 percent, females 5 to 14 years of age make up 12.5 percent and females younger than 5 make up 6.2 percent of the female population. An estimated 81.1 percent of the population in Ohio resides in metropolitan areas. The 10 counties with the largest populations are Cuyahoga, Franklin, Hamilton, Montgomery, Summit, Lucas, Stark, Butler, Lorain and Lake. The 88 counties are categorized as metropolitan (11), suburban (16), rural non-

Appalachian (29) and Appalachian (32).

Since 1990, Ohio has had an increase in ethnic minorities as a percentage of the population. The Hispanic population, composed mainly of persons of Mexican and Puerto Rican origin, has grown 22.4 percent since 2000. Likewise, since 2000, the black population has grown 5.6 percent. The three largest groups of Asian populations in Ohio are of Indian, Chinese and Vietnamese origin. In 2008, 86.6 percent of the population was white, 8.0 percent was black, 0.8 percent was Asian and 1.6 percent was Native American and Alaskan Native. These groups may also include Hispanics who made up 2.3 percent of the population. There are several special populations of note in Ohio. The migrant population continues to slowly increase. Between 2003 and 2004, this population increased by 4%. Ohio is also home to the nation's largest concentration of Amish, with about 40,000 residing in a five county rural area. Holmes County alone is home to 19,000 Amish. Ohio has also experienced an influx of immigrants, both from primary resettlement of refugees as well as secondary migration from other states.

Ohio's age distribution has gone through a change in the past 10 years. The first half of the baby-boom generation has moved into empty-nester household stage. The 65 and over age group has experienced the slowest growth in three decades due to inclusion of smaller WWII veteran and Great Depression cohorts. Gaining only 3.2 percent growth statewide, growth in the under-18 age group is limited to areas of larger total population growth. Ohio births have declined from the baby boom high of about 243,000 in 1957 to just over 148,000 in 2008. In 2008, the population of children through age 24 was 3,812,111 representing 33 percent of the total population. Youth as a percentage of the state population is projected to continue to decrease. This trend is consistent with the national trend.

According to ODH Vital Statistics, there were 148,592 live births to Ohio residents in 2008. By mother's race, births were distributed as follows: white, 75.7%; black, 15.9%; all other races, 8.4%. The Ohio resident live birth rate decreased over the period 1994 to 2008, from 14.3 births per 1,000 population, to 12.9 per 1,000. The white rate followed the same pattern, while the black rate declined until 2003, at which point it increased from a low of 16.1 births per 1,000 to 18.1 in 2008. In 2008, Hispanics experienced the highest live birth rate of all racial/ethnic groups examined, and this was the only group with a marked increase across the period. This finding is consistent with national birth trends. Implications: Hispanic birth outcomes will exert greater influence on overall Ohio birth outcomes assuming the Hispanic population continues to represent an increasing proportion of Ohio births over time. While, the proportion of all births that were Hispanic increased 2.7 fold between 1994 and 2008, Hispanics still represented only 4.6 percent of all Ohio live births in 2008.

Ohio has 4,508,871 total households. A household consists of all the people who occupy a housing unit. A household may include the related family members and all the unrelated people, if any, such as lodgers, foster children, wards or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household. There are two major categories of households, "family" and "non-family." Sixty-five percent of Ohio households are family households; approximately 31.6 percent of family households include children under the age of 18 years. Forty-eight percent of family households are married-couple families; 16.8 percent are single-parent households. Approximately 33.8 percent of these single-parent households are female householders with no husband present (this excludes single women who live with the child's father and single teenage moms who live with a parent or other relative). The percentage of births to single mothers has increased from 34.0 in 1997 to 43.2 in 2008. The number of single mothers in Ohio has increased 3 times since 1960, to 704,965 in 2008. In Ohio, 78.2 percent of all black births were to single mothers, whereas 36.3 percent of all white births were to single mothers according to 2008 records.

According to the 2005/2006 National Survey of Children with Special Health Care Needs (CSHCN), the total number of children with special health care needs in Ohio was 445,205 or

16.2 percent of children under 18 years of age. The survey identified 381,667 Ohio households with children with special health care needs or 23.9 percent of the state's households. In comparison, the survey identified 10.2 million children with special health care needs nationally or 13.9 percent of children under 18 years of age. Nationally, 21.8 percent of all households had a child with a special health care need.

The percentage of Ohio women who work continues to increase, with 60 percent of the female civilian population over age 16 participating in the labor force in 2004, up from 58 percent in 1994. The percent of women in the labor force is projected to continue to increase over the next 10 years. Ohio Asian women lead in pursuing higher education with 31 percent of those 25 years and older holding at least a bachelor's degree, compared with 15.6 percent of non-Hispanic white women, 9.6 percent of black women and 11.3 percent of Hispanic women. In 2008, for those 25 years and older, the educational levels of women are lower than men. Roughly 28.8 percent of women in this age group have completed college compared with 30.1 percent of men.

In 2008, 13.3 percent of Ohioans were living below the federal poverty level. This is similar to the national rate of 13.2 percent. The poverty level; however, varies greatly by county. The five counties with the highest poverty rates were Athens (29.6 percent), Vinton (23.0 percent), Adams (21.9 percent), Morgan (21.1 percent) and Jackson (20.7 percent). The five counties with the lowest poverty rates were Delaware (4.9 percent), Medina (5.8 percent), Warren (6.6 percent), Geauga (6.9 percent), and Union (7.1 percent).

Within metropolitan areas, the average poverty rate for Ohio cities was 18.9 percent, compared to 6.5 percent for areas outside of the central cities. Eight central cities had poverty rates greater than 20 percent: Cleveland (26.3 percent), Bowling Green (25.3 percent), Kent (25.2 percent), Youngstown (24.8 percent), Dayton (23.0 percent), Lima (22.7 percent), Cincinnati (21.9 percent) and Steubenville (20.4 percent). The counties with the highest poverty rates are located in Appalachian Ohio. Two-thirds of Ohio's poor are white, yet this racial group has the lowest poverty rate--10.8 percent in 2008. The poverty rate was 29.3 percent for blacks, 12.3 percent for Asian and 24.8 percent for Hispanics. The risk of poverty varies by the type of household in which people live and whether they have children. Although not generally considered a minority group, residents of Appalachian counties differ from other Ohioans. A report by the Central Ohio River Valley Association mapped the mortality rates in southern Ohio's Appalachian counties. These areas showed higher death rates due to all causes compared with overall Ohio rates. Factors contributing to higher rates included poverty, lack of health services, lack of health insurance and possible lifestyles and health behaviors of Appalachian Ohioans.

Families with children are at greater risk of being poor than families with no children and the risk among families headed by a woman with no spouse present is much larger. Those with at least one child had poverty rates only three to ten times higher than the rates of those with no children. The age groups characterized by higher-than-average poverty rates are children (ages 0 to 17 years). The higher poverty rate for children may be partly explained by the larger proportion of one-parent families. Children are the poorest people in Ohio: 18.5 percent of children under 18 years old lived below the poverty level in 2008. The poverty rate for the total population decreased from 1994 (14.2 percent) through 2008 (13.4 percent). Overall, the rate for children under 18 years decreased from 1994 (20.9 percent) through 2008. Of the 2,936,172 families currently estimated to be below the poverty level, 48.5 percent of those families have related children younger than 18 years of age.

There were 389,259 families with female heads of household that fell below the federal poverty level in 2008. Approximately 68.5 percent of families with female heads of household had related children 18 years of age and younger. The unemployment rate in Ohio was 10.8 percent in January 2010, which was higher than the national average of 9.7 percent for the period. Since January 2006, when the unemployment rate was 5.4, Ohio's unemployment rate has risen drastically, which is consistent with the national trend.

Like other states, Ohio suffers from a shortage of primary care, dental care and mental health care providers in a number of communities and counties. Attempts at enumerating shortage areas center on those that have gone through the process of being designated a federal Health Professional Shortage Area (HPSA). The data; however, does not present the whole picture because many areas that might qualify as HPSAs do not apply. (A full description and the HPSA maps are more thoroughly discussed in the Needs Assessment) Ohio has 127 total primary care HPSA's located in 51 of its 88 counties. Eleven are whole county, 21 geographic but not the whole county, 34 are for special population groups, and 58 are facility HPSAs. They include much of rural Ohio and parts of every major city in Ohio (Cleveland, Cincinnati, Toledo, Columbus, Dayton, Youngstown, Akron and Canton). The 98 dental HPSAs in 46 counties are more evenly distributed with 29 located in metropolitan areas and 30 located in non-metropolitan areas. In Ohio, disparities in oral health and access to care have been linked to low family income, residence in an Applachian county, and race. Ohio has 65 mental health HPSA's: 7 whole county, 12 geographic areas, 4 special population, and 42 facilities. Thirteen geographic designations indicate a need for 19 psychiatrists to serve a population of more than 907,000 Ohioans. Of the 19 counties within these geographic designated areas, 12 are in the Appalachian region. The remaining three mental health HPSAs have been designated for facilities (one state prison and two state psychiatric hospitals).

Title V Health Care Delivery Environment:
As noted, Ohio has a large population of women of childbearing age, children, and children with special health care needs, making its Title V MCH program critical to the health of a large portion of the state's population. Sometimes influencing care (e.g., through partnership s with Medicaid, Mental Health and the Department of Developmental Disabilities) sometimes through funding services to fill gaps in the safety net (e.g., family planning, prenatal child health, and children with special health care needs); and in a two small instances providing care directly (e.g., vision, hearing clinics). Dollars expended on direct service at the local level are used to augment the publicly-funded safety net. Medicaid and other third party payers are billed by local clinics, while Title V funds are used for those persons who have no other means of paying for services. These grantees are often local health departments, but they may also be hospitals, community action agencies, and other non-profit community agencies.

Ohio's Title V Program is able to work within these programs and initiatives and has become more efficient and responsive to the needs of the MCH population. For example, within the Child and Family Health Services (CFHS) program, local agencies that receive Title V funds are familiar with MCH Block Grant performance measures and prepare their grant applications to ODH by population group and level of the MCH service pyramid, based upon their own county-level needs assessment. The CFHS Program is a network of clinical service providers, and local consortiums of health and social services agencies that identify the health needs, service gaps, and barriers to care for families and children and then plan clinical and community public health services to meet those needs. It also assures clinical child and adolescent health, prenatal, and family planning services for some low income families and children (e.g., legal immigrant children, and pregnant women, ineligible for Medicaid by federal mandate even if otherwise meeting family income guidelines). Funding of 71 local sub-grantees is done with a combination of Title V and state general revenue dollars. CFHS consortiums are linked to the county Family and Children First Councils, Medicaid, and the Help Me Grow program. CFHS Projects are necessary even though Medicaid provides substantial funding of health care for the MCH population. For those children residing in Medicaid mandatory managed care counties, the CFHS clinics are one of the choices that the family would have for a child health care provider. In many rural counties however, the CFHS clinic may be the only provider in the community who will accept Medicaid eligible clients, and those with no ability to pay for services.

ODH has been working with the six Regional Perinatal Centers for the past decade to address perinatal quality improvement by stimulating the use of data to identify needs and then implement and evaluate interventions based on current evidence. Progress has been made in developing Ohio's capacity to address perinatal health in this way. Ohio is now ready to take this approach to the next step and apply the quality improvement science in a broader way. In order to expand the effort, ODH will be redirecting the funds that currently support the Regional Perinatal Centers and the quality improvement work to an enhanced initiative in partnership with Ohio Medicaid. This will allow the state to draw down a federal match which will significantly increase the total investment. ODH will work with partners to establish a network of Quality Improvement Coordinators to support the spread of the quality improvement science approach and the various QI projects currently underway.

Federally Qualified Health Centers (FQHCs) play a vital role in the delivery of primary and preventive care to pregnant women, mothers, infants, children, adolescents, and CSHCN. Financial resources are distributed to provide improved access to health care for the Maternal and Child population. A total of 88,897 unduplicated patients (pregnant women, children less than 1 year old and children 1-18 years old) received care in FQHC's or in the free clinics throughout the state in 2007.

Currently there are 129 local health departments in Ohio. Sixty-four of Ohio's 88 counties have one health department. The other 24 counties contain 65 departments, an average of nearly three per county (for the 24 counties). Ohio is a "home rule" state; the state health department does not have authority over local health departments except through some statutory requirements for environmental health and subsidy. ODH implemented Local Health Department Improvement standards available at http://www.odh.ohio.gov/LHD/PSWstan.pdf which do not represent an increase in the number of standards pertaining to subsidy, but they do represent a change toward a continuous quality improvement approach. The Ohio Department of Health is participating as a beta site for testing the new public health standards, as developed by the Public Health Accreditation Board.

Title V FFY 2011 MCH Needs Assessment, Priorities and State Performance Measures
During 2007 and 2008, in anticipation of the Fiscal Year 2011 Maternal and Child Health Block Grant (MCH BG) application, Ohio conducted a comprehensive assessment of the health needs of women, children and families in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions and professional judgment from those working in the field. The needs assessment process and resulting priorities have been used to guide Ohio's MCH BG funded activities and grant application for 2011.

To determine the most critical needs of the state's maternal and child health population leadership within the Ohio Department of Health (ODH) Division of Family and Community Health Services (DFCHS) (division chief, six bureau chiefs and an external facilitator) collaborated on the most effective way to include stakeholders in a structured prioritization process. Five (5) key areas were identified as being essential for a successful outcome: the convening of four (4) day long stakeholder meetings including; sharing of data that outlined health social indicator status, health and social services access related to the MCH population from an Ohio and national perspective; identifying best, promising or evidence based practices implemented across the state for the MCH population; utilizing a drilled down -analysis approach to identifying potential interventions related to the prioritized health issues; the incorporation of an evaluation tool at each phase of the process to determine what worked and what didn't.

ODH initiated the MCH Block Grant needs assessment process well in advance of the FFY 2010 submission. In the summer of 2008 Ohio's Title V leadership assembled to develop plans and timelines for completing the BG needs assessment and application for the July 2010 deadline. During October-December 2008, meetings were held to engage stakeholders in discussions around the prioritized health issues within four maternal and child health areas of concern; early childhood; school-age children, adolescents and young adults; children with special healthcare needs; and women's health, birth outcomes and newborn health. Each session included participants from across Ohio representing state agencies, foundations, insurance providers, professional organizations, local public health agencies, consumer, and other affiliated organizations. The product from each group discussion was an agreed upon list of prioritized health issues for the sub-population being discussed. ODH provided stakeholders participating in the prioritization process with a compilation of quantitative data specific to their population group. The data were primarily organized into topic areas in a fact sheet format. Data sources included state and national Vital Statistics, PRAMS, Youth Risk Behavior Survey (YRBS), www.cdc.gov/nccdphp/dash/yrbs/index.htm, Behavioral Risk Factor Surveillance Survey (BRFSS), www.cdc.gov/brfss/technical_infodata/surveydata.htm, Ohio Family Health Survey (OFHS), http://grc.osu.edu.ofhs, Census, Disease Surveillance and ODH program statistics.

Prior to each face-to-face meeting, participants were engaged in an individual-level issue prioritization exercise. They were provided with a list of 25 pre-identified health issues for the sub-population they were invited to represent. Individuals then ranked these 25 issues in importance using the "Q-sort" method. Mean rankings and standard deviations for each mean were calculated prior to each face-to-face meeting. To begin the discussion of health issues, participants reviewed a compiled list of health issue feedback gathered from a separate stakeholder survey conducted by ODH. This information was sought from practitioners and providers across Ohio and provided a local perspective to the issues for each sub-population. All groups except the early childhood stakeholders generated a list of recurring themes within these local stakeholder survey results. This list was used as a reference point throughout the issue prioritization phase of the meeting that followed. After reviewing and generating a list of recurring themes from the local stakeholder survey, participants were provided with the results of their Q-sort exercise. After a brief discussion of the results in general, the participants began a discussion of individual issues.

Staying connected to the process, using legislative mandates, and political and community driven concerns as a filter, MCH Leadership collectively identified the state's nine critical MCH priority needs. These nine critical priorities fall within three categories; improve the health of children and adolescents; increase positive pregnancy outcomes and preconception health; and system improvement. The nine priorities are not ranked in any specific order of importance within and/or among Categories: 1) Increase physical activity and improve nutrition, 2) Increase breastfeeding initiation and duration, 3) Improve early childhood development, 4) Decrease smoking among pregnant women, young women and parents, 5) Increase the viability of the health care safety net, 6) Increase the number of women, children and adolescents with a health home, 7) Increase access to evidence based community prevention programs, 8) Increase successful transition of special needs children from pediatric/adolescent to adult health care systems, 9) Improve the availability of useful and accurate health care data and information (specifically related to quality and capacity). Once the critical priorities were identified, MCH Leadership selected the new FFY 2011 -- 2015 State Performance Measures (SPMs) that reflect both a community and professional perspective around maternal child health care needs in Ohio. Throughout the process the Division and Bureau Chiefs played a pivotal role in connecting with the stakeholders at every level, and they ensured that stakeholder questions and concerns were appropriately addressed while adhering to and sharing the political and legislative mandates that govern ODH. This process allowed ODH to select performance measures and action plans, which will drive its allocation of resources and monitor the progress and outcomes of Ohio's MCH population.

Title V Current or Emerging Challenges
While conducting the needs assessment ODH identified major challenges that participants (including youth, parent and family members, professionals, policy makers, and MCH program staff) felt were impacting the delivery of healthcare services. Global challenges revolved around the diminishing access to health care and health-related services across the state, the significant cuts to and availability of funding for MCH services and the current state of the economy.

Some of the challenges by population consist of the following; Early Childhood, School-age, Adolescents and Young Adults: low-income children and adolescents getting access to dental care, obtaining health insurance coverage, comprehensive services including immunizations, oral health, vision, hearing, lead screening, behavioral and mental health screening, providers accepting Medicaid, public awareness and information and trainings, the identification that motor vehicle crash is the leading cause of unintentional injury related death among children 14 years and under. Children with Special Health Care Needs: lack of adequately trained pediatric providers in some geographic areas, lack of family and provider resources in Appalachia, rural, inner city, reduced funding in recent years is impacting outreach and services to families, lack of funding for those portions of health care services not covered by other funding services, including physical, occupational, speech, behavioral therapies, special equipment and medical supplies, assistance with navigating benefit systems regarding services and eligibility requirements, coordination among complex government programs, access to providers. Women's Health, Birth Outcomes and Newborn Health: diminishing financial support, erosion of local programs, resistance of schools to fully address use of contraceptives, lack of prenatal care providers, overall Ohio economy, providers not accepting Medicaid, obtaining culturally appropriate family planning materials, communities having healthcare workers to improve access to care, quality data and information for policy development and program planning for legislators. A comprehensive list of identified challenges by population groups can be accessed by viewing the Needs Assessment of Ohio's Maternal and Child Health Populations.

/2012/ As the flagship of Ohio's public health infrastructure, ODH works with 127 local health departments to provide local services, and has more than 150 programs of its own. ODH's new Director, Dr. Ted Wymyslo, is part of the state's team of Health and Human Services (HHS) partners working as the governor's Office of Health Transformation (OHT) to protect and improve the health of all Ohioans, while transforming the Medicaid system.

The OHT's mission is to transform Ohio into a model of health and economic vitality. To bring the system back in line with principles that demonstrate a commitment to the State's health care delivery environment such as: reset the basic rules of health care competition so the incentive is to keep people as healthy as possible, rely on evidence and data to complement a lifetime of experience, so doctors can deliver the best quality care at the lowest possible cost, pay only for what works to improve and maintain health, and stop paying for what doesn't work, transform primary care from a system that reacts after someone gets sick to a system that keeps people as healthy as possible, prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and help reduce chronic care costs and innovate constantly to improve health and economic vitality.

Dr. Wymyslo came to the Department after 30 years as a family practice physician and considerable expertise in the practice transformation to Patient Centered Medical Homes. His guidance and support in that inititiaitve as it pertains to pediactric care will be invaluable. Administratively he has streamlined the upper layers of the organization and hired a new COO who comes to the Department with experience as a local public health commissioner and 10 years as a health issue lobbyist in the Ohio legislature.

The current and most challenging issues facing Ohio are the budget deficit and cuts to state funding. Governor Kasich has challenged state agencies to come up with ways of assuring high quality services that result in improved outcome while reducing costs. In support of the Governor's challenge and furthering Ohio's mission of advancing health outcomes for children though partnerships and improvement science, the public/private partnership known as the BEACON (Best Evidence for Advancing Childhealth in Ohio NOW) Council hosted a Quality of Care Measurement Conference on February 8, 2011. The BEACON Council is a collaborative effort led by ODH and the Department of Job and Family Services (ODJFS) Medicaid Office that is also fully aligned with the Governor's OHTs quality improvement strategies.

At the conference the OHT presented Ohio's planned pursuit of quality improvement strategies to improve care delivery while reducing Ohio's Medicaid costs, and other leading health care experts highlighted specific programmatic and cost reduction opportunities applicable to Ohio's Medicaid program. Utilizing the Medicaid data an high cost and high prevalence conditions participants were challenged to identify priority areas that would achieve the goal of cost reduction while either maintaining or improving quality. The morning breakout session resulted in the identification of five quality improvement focus areas, including: prenatal and neonatal care; care coordination; access to quality behavioral health care; patient safety; and targeting specific populations with chronic conditions (e.g. asthma). For the afternoon sessions, conference participants were assigned to one of these five groups and were asked to articulate the problem, identify target aims, key drivers, potential interventions and desired outcomes.

In addition, attendees recommended specific initiatives and pilot projects taking place in Ohio or other states that could be considered as possible initiatives in the next biennium. These identified strategies will assist the BEACON Council in its efforts to integrate Ohio specific child health quality improvement strategies with federal and state efforts to improve health care quality and reduce costs. Proposals for implementing the strategies will be considered by the BEACON Council and those that align with Ohio Medicaids Quality Agenda may be considered for Medicaid matching funds. The FY2012 projects will begin in August.

Related to the Ohio needs assessment, several activities have occurred related to our assessment and priorities in Ohio. First, in preparation for application for voluntary national accreditation through the Public Health Accreditation Board, ODH is developing a comprehensive state health assessment. The goal of the national accreditation program is to improve and protect the health of every community by advancing the quality and performance of public health departments. A board including both state and local advisors is overseeing the Ohio assessment. A total of 12 prenatal indicators, 17 perinatal indicators, 5 infant health indicators, and 32 child/adolescent indicators are included. Care was taken to include indicators in the state health assessment of priorities that were already chosen from the recent Title V needs assessment process. Based on the final state health assessment (scheduled to be completed in summer of 2011), a state health plan will be completed before the state is eligible to apply for accreditation. Also of importance to the Title V needs assessment, the state's PRAMS annual plan was written to address the selected priorities. The plan includes the production of analyses and fact sheets around Title V priorities where PRAMS data are available to address those priorities. //2012//

***/2013/ The Ohio Department of Health (ODH), in partnership with the Governor's Office of Health Transformation (OHT), will invest $1 million to assist primary health-care practices around the state transition to a patient-centered medical home (PCMH) model of care and expand the number of PCMH practice sites in Ohio. The PCMH model of care promotes partnerships between patients and their primary health-care providers to improve care coordination and bolster individuals' health outcomes. Patient care is coordinated using state-of-the-art tools such as registries, information technology, health information exchange and other means to assure that individuals get appropriate care when and where they need it. In addition, Ohio will give priority to practices that serve underserved or minority populations, and at least 15 percent of every practice that receives training dollars must support either uninsured or Medicaid-eligible Ohioans.***

***Ohio continues to address MCH healthcare issues through its BEACON Council, a statewide public/private partnership which encourages and supports initiatives that achieve measurable improvements in children's healthcare and outcomes through improvement science. Accomplishments in 2011 include the Autism Diagnosis Education Pilot Program (ADEPP) 2008 -- 2011 Concerned About Development Learning Collaborative that saw improvements where 108 Primary Care practices were trained between Sept 2008 -- December 2010; 74% of the practices see greater than 25% Medicaid patients; 935 licensed pediatricians trained out of 2173 licensed in Ohio; increase in screening from less than 15% to between 72-90%; average % of kids who received ASQ at 9 months went from 13% to 85%; average % of kids who received ASQ-SE at 12 months went from 0% - 97%; average % of kids to receive an ASQ at 18 months went from 13% to 83%; average % to receive MCHAT at 24 months went from 20% to 90%; all pediatricians who participated in QI Learning Collaborative participated in the program for 8 months.***

***The BEACON Council hosted its second annual retreat on February 3, 2012 attendees recommended specific initiatives for Ohio to considered as possible quality improvement projects. The strategies identified assist the BEACON Council in its efforts to improve health care quality and reduce costs. Current ODH funded BEACON projects include; the Children's Mental Health Learning Collaborative, the Ohio Obesity Project, and the Ohio Perinatal Quality Collaborative.***

***In collaboration with its public health partners ODH has developed a 2011 State Health Assessment (SHA) plan which represents the first step in a multi-part process to identify and better address the population health needs of the state. The second step will involve the creation of a State Health Improvement Plan (SHIP), utilizing the SHA as well as other data sources, to identify and prioritize goals and objectives to help fulfill the public health system's mission to protect and improve the health of all Ohioans. The health assessment includes 11 areas of focus addressing disease burden, including data on the leading causes of death in Ohio; the prevalence of certain chronic, communicable, and infectious diseases; unintentional and intentional injury rates; health behaviors, clinical risk factors, and recommended care; maternal and child health; health system access; and environmental health indicators. ODH will utilize information from the 2011 State Health Assessment to inform its next Strategic Planning process. The Title V program is engaged in the process and will closely monitor the goals and objectives that are identified for the MCH indicators in the plan. The indicators outlined in the SHA are directly related to the MCH priorities identified through the Needs Assessment process.***

***ODH is a sponsor of the Ohio Collaborative to Prevent Infant Mortality a statewide organization working to improve birth outcomes and survival during the first year of life. Membership in the collaborative is made up of representatives from business, medicine, government, public health, and advocacy groups and includes the Ohio Chapter of the March of Dimes, the Ohio Chapter of the American Academy of Pediatrics, the Ohio Section of the American Congress of Obstetrics and Gynecology, as well as major hospitals. Dr. Arthur R. James of the OSU Medical Center and Lisa Amlung Holloway of the Ohio Chapter of March of Dimes are the organization's co-chairs. Because Ohio's IM rate has remained stagnant for over a decade, the ODH Director has called for an ODH Infant Mortality Caucus to review important aspects of IM and to make sure everyone in the department whose work touches on infant mortality, even indirectly, is knowledgeable and committed to marshaling resources for change. The Director's charge is for everyone to work together both inside and outside the department to achieve healthier women, better birth outcomes and healthier babies who live to become healthy children and productive adults.***

***Ohio was one of three states (CA, NY) that received $350,000 a year for three years from the Centers for Disease Control and Prevention (CDC) for the State-Based Perinatal Quality Collaborative Grant Program. Partners include the Ohio Department of Health (MCH, Vital Statistics, and Data Center) and the Ohio Perinatal Quality Collaborative (OPQC). The project proposes to decrease neonatal sepsis and unnecessary scheduled births at 36-39 weeks in Ohio hospitals. Additionally, the project will focus on improving the accuracy and quality of birth certificate data and feedback of performance metrics and reporting systems.***

***Ohio successfully completed a second year of the Pregnancy Associated Mortality Review (PAMR) system. The PAMR is being sustained by funding from the MCHBG. Forty-two cases from 2009 were abstracted and reviewed by the PAMR Board. Next steps include designing interventions for quality improvement and enhanced evaluation.***

***The CYSHCN program is the Title V partner on the "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation Grant for CYSHCN which was awarded to Dr. Pam Oatis at Mercy St. Vincent Medical Center in Toledo, Ohio. Together with Dr. Oatis***

*and the grant's third key partner, Family Voices of Ohio, we are providing training in the principles and practice of medical home and "Listening with Connection", a communication skill building program. Trainings will reach direct service providers across the state including Public Health Nurses, Family to Family Health Information Specialists and Early Intervention Service Coordinators who can then partner with families in decision making and increase demand in communities for medical home services. In the next phase, facilitators will be trained to implement the medical home curricula and "Listening with Connection" in local communities with other Help Me Grow workers, Children's Hospital Parent Advocacy Committees, school nurses and other target audiences. We are also partnering with "REAL Action in Ohio: Resources, Education, Alignment and Linkages", the HRSA State Implementation Grant for Autism and Related Developmental Disabilities which was awarded to the Ohio Department of Developmental Disabilities. This grant is also planning development and dissemination of materials for families about medical home. We will facilitate collaboration between these two projects to ensure a unified message for our Ohio families which can be spread through our medical system, early intervention system and home visiting system. This will improve our ability to address medical home for CYSHCN statewide and will improve how service providers across systems partner with families in decision making.*

*The Office of Performance Improvement oversees the Center for Public Health Statistics and Informatics (CPHSI) also known as the Data Center, is a centralized area responsible for the collection, analysis, dissemination and use of health data that provides support to MCH programs. The Data Center continues to manage the SSDI Grant and continues to make progress in many targeted areas. The data sharing agreement with the Ohio Hospital Association (OHA) was expanded to improve the process for gaining access to OHA data. In addition, OHA has recently made race and ethnicity information available to ODH for the first time. A new contract for statistical consultation has been agreed upon and is currently being developed with Case Western University. The ODH data warehouse is under development and SSDI funds have contributed to availability of real-time live birth data feeds from vital records for the first time. SSDI also funded creation and completion of automated reports for all block grant performance and outcome measures depending on vital birth records.*

*An epidemiologist devoted exclusively to SSDI goals was hired and has created linked birth/mortality final files for birth cohorts 2006-2010, and a preliminary file for the 2011 birth cohort. This has made it possible for SSDI and other MCH epidemiology staff to address numerous data requests and questions on Ohio birth outcomes that would not previously have been possible due to lack of up-to-date information.*

*Discussions between the ODH WIC program, other MCH programs, and the ODH Data Center (including SSDI staff) are underway to incorporate WIC information into the data warehouse, with the goals of automating reports similar to CDC's former PNSS and PEDNS publications, and for automating linkage of WIC with Vital Records. Plans were agreed upon for the SSDI epidemiologist to play a central role in this project.*

*In the current funding period, several analyses were completed or are in progress. Topics of analyses include preterm causes of mortality; infant mortality patterns among late and early preterm infants; comparison of infant mortality among Somali and black mothers in Franklin County, Ohio; birth outcomes by hospital obstetric level; annual Medicaid and VS summaries for Title V annual reporting; hospital discharges among patients with sickle cell disease; fact sheets on preterm births, low birth weight and other birth outcomes. //2013//*

## B. Agency Capacity

## Section III B. Agency Capacity

### Methods for assessing MCH populations & Determining Agency Capacity

Ohio utilizes the Community Health Improvement Cycle model to review and assess its capacity for delivering essential services. The model dictates a process built on self assessment; external assessment; building partnerships; planning; data needs/capacity; priority setting; action plan/interventions; implementation and evaluation. DFCHS engaged the MCH Advisory Council whose primary role is advising on block grant funded programs and the population served by the Title V Program to participate in the review and assessment process. The Council is composed of maternal and child health consumer and family members, professionals in both public and private sectors, clinicians, administrators, policy makers, MCH advocates, state agency representatives, academicians and state legislators and appointed by the Director of Health.

The most important health care needs and issues were identified by population group, and resulted in a comprehensive assessment of the state's maternal and child health population. A final prioritization of participant-generated health issues can be found in the FFY11 Needs Assessment. Below by population are some of the priority health issues and agency recommendations:

Early Childhood, School-age, Adolescents & Young Adults - Priorities: Increase access to adequate & culturally appropriate prevention, early identification, treatment services; prevent unsafe behaviors such as substance use, risky sexual behaviors, violence & behaviors most likely to cause intentional/unintentional injuries/illness; provide family-centered services/education to support child/family health/wellbeing; recognize/reduce the negative impact of social determinants of child & adolescent health; reduce environmental exposures that contribute to chronic illness, injury & disability. Recommendations: identify successful prevention programs based on or informed by an existing body of evidence & link programs through a network of partners; identify/encourage best practices related to access/utilization of child/adolescent health services; identify strategies/incentives to promote multi-disciplinary collaboration/coordination at the local regional/state levels; build body of Ohio-specific evidence/data for cost-effectiveness of prevention, include a case management/care coordination component in appropriate programs to increase patient/family compliance & overall access to appropriate care.

Children with Special Health Care Needs (CSHCN) - Priorities: Increase number of standardized medical homes for CSHCN; increase capacity for the medical home to screen, diagnose/access comprehensive medical/non-medical specialty services through the use of evidence based tools; provide families with support & networks needed to participate in all aspects of family care; enhance system of reimbursement for basic primary care services, provide incentives for innovative service delivery; improve capacity to collect/utilize available CSHCN data to drive future decision making. Recommendations: collect/analyze sub-county level data that shows how many CSHCN are living in Ohio & how many are currently left unserved; work with providers & other stakeholders to create a viable model, including funding, for the medical home that is multidisciplinary (i.e. medical, educational & social services); engage consumer & family advocates to expand & support sustainable patient & family advocate/navigator programs; partner with private entities & other non-traditional partners to leverage expertise in system development.

Women's Health, Birth Outcomes & Newborn Health - Priorities: Provide comprehensive reproductive health services/service coordination for all women/children before, during/after pregnancy; eliminate health disparities & promote health equity to reduce infant mortality; prioritize/align program investments based on documented outcome/cost effectiveness; implement health promotion/education to reduce preterm births; improve data collection/analysis to inform program/policy decisions; increase public awareness about the effect of preconception health on birth outcomes; develop, recruit/train a diverse network of culturally competent health professionals statewide. Recommendations: Increase public utilization of resources such as the Ohio Benefit Bank to assist women/children with obtaining health care services; ensure access to providers, including advanced-practice nurses, who accept Medicaid & provide family planning services/care for high-risk pregnancies in all parts of Ohio; ensure that all women of childbearing age & their families have access to appropriate mental health services/substance abuse programs; implement/evaluate a social marketing campaign to increase public awareness of the prevalence of infant mortality & disparities that exist in Ohio; support implementation of the recommendations of Ohio Anti-Poverty Task Force; require any agency or group that receives public funding for MCH programs to identify measurable outcomes & publicly report their findings/outcomes.

ODH is the designated state agency for implementation of the Title V Maternal & Child Health Block Grant (MCH BG) & established the DFCHS for this purpose & for the purpose of ensuring provision of MCH programs at the state/local level. DFCHS is responsible for the following state statutes that impact the Title V program: 1) Birth Defects Information System (BDIS); 2) Child Fatality Review (CFR); 3) Lead Poisoning; 4) Save Our Sight Program; 5) Sudden Infant Death; 6) Universal Newborn Hearing Screening; 7) Vision/Hearing Screening; 8) Women's Health Services (WHS); 9) Shaken Baby Syndrome (SBS); 10) Abstinence & Adoption Education Guidelines; 11) Genetics Services Program & Sickle Cell Services Program.

PROGRAM CAPACITY - Bureaus within DFCHS are responsible for administering the MCH-related programs & coordination with non-MCH BG programs. DFCHS has approximately 60 different funding sources supporting its public health programs. To ensure ODHs capacity to promote & protect the health of mothers & children including CSHCN, & address the priority health issues, the following preventive & primary health care services are administered within DFCHS Bureaus through Ohio's Title V programs. The list of programs indicated below reflect the comprehensive, community-based, and family centered care provided by Ohio that is essential in protecting the health of all mothers, children and CSHCNs. ODH has selected 9 MCH Priorities that fall within 3 categories; improve the health of children and adolescents; increase positive pregnancy outcomes and preconception; and system improvement. These priorities were selected because they address the important health care needs and issues that were identified via the Needs Assessment process. All 9 priorities are reflected through the programs listed below. These programs are on-going and a broader description of each can be found by visiting the ODH website at www.odh.ohio.gov .

Birth Defects (BD) Information System (BDIS)
Child & Family Health Services Program (CFHS)
Healthy Child Care Ohio (HCCO)
Preconceptional & Interconceptional Health Services Family Planning (FP)
Prenatal Smoking Cessation Services Program (PSCP)
Primary Care/Rural Health Program (PC/RH)
Save Our Sight Program (SOS)
School Nursing (SN) Consultation
Services for Children with Special Health Care Needs (CSHCN)
Sickle Cell (SC) Services Program
Shaken Baby Syndrome Education Program
Special Supplemental Nutrition Program for Women, Infants, & Children (WIC)
Specialty Medical Services Program (SMSP)
Sudden Infant Death Program (SID)
Women's Health Services Program (WHSP)

While the programs listed above remain a part of Ohio's capacity to provide preventive and primary care services for its MCH population, the programs described below represent some of the new and innovative approaches to addressing the 9 MCH Priorities for FFY 2011 - 2015.

MCH Priorities 1, 3 and 7 are linked to and addressed through the following programs:

School and Adolescent Health Programs (SAH):

Action Learning Collaborative on Preconception Health for Teens:
The Preconception Health and Adolescents Action Learning Collaborative project sponsored by AMCHP in partnership with ASTHO is working to expand state-level preconception health efforts to include adolescents. Ohio is one of six state teams awarded this opportunity to receive technical assistance in creating strategies to implement the Centers for Disease Control and Prevention (CDC) Recommendations to Improve Preconception Health and Health Care with adolescent populations. ODH is partnering with the ODE to develop an adolescent health framework that can be used across sectors and disciplines to assist health care and education professionals in teaching health literacy to teens in a holistic manner. To view the draft framework go to: www.amchp.org/groups/Preconception-Health-Adolescents-ALC/Pages/default.aspx

Body Mass Index Surveillance Project:
School and Adolescent Health staff have developed a BMI surveillance program that involves obtaining heights and weights of 3rd and 7th graders throughout the state of Ohio. Childhood Obesity is one of the Governor's and Director of Health's top priorities. In addition physical activity and nutrition were the top priorities identified during the needs assessment process this past year. BMI data collection for the 3rd grade population occurs in conjunction with the Oral Health Program's Open Mouth Survey. By combining both surveys into one effort the ODH maximizes resources while limiting intrusion into schools. In addition to the third grade survey, which collects state and county level data, the School and Adolescent Health Section collects 7th grade BMI data at the state level every other year. The data are used by stakeholders and other ODH programs as a benchmark for evaluating progress and success of interventions targeted to impact childhood obesity. Training and technical assistance is offered to schools and local public health departments each year to assist in building local data collection efforts.

Nurse Impact SIIS Project:
School and Adolescent Health programs have improved schools ability to track immunizations using the Ohio Immunization Registry, Impact SIIS, thereby reducing the need for student exclusion from school. School Impact SIIS is a secure Web based, quality assurance tracking tool used by public and private sites in an effort to raise immunization rates and meet healthy people 2010 goals! ORC 3313.671 requires schools to collect satisfactory written evidence of student immunization according to ODH's approved schedule. Students without satisfactory immunization documentation should be excluded after 14 school days until documentation is provided. Recent data from a small sampling of schools indicates that more than 68% of their student population was kept from being excluded for lack of immunization records.

Oral Health Initiatives:
ODH was notified in late August that the two HRSA grant applications submitted earlier this year were approved for funding starting September 1, 2010.
1. ODH received supplemental funds for the HRSA Workforce Grant initially awarded in Sept. 2009. These additional funds will be used for the same purpose as the current funds in this grant, to further restore funding cuts sustained in 2009 by the Safety Net and dental OPTIONS subgrant programs.

• OPTIONS funding will be restored to previous funding levels and some additional funding will be available. This will enable more uninsured Ohioans with low-incomes to receive needed dental care provided by volunteer dentists in their offices.

• Safety Net grant funds will be used to provide dental care to additional Ohioans who qualify for dental care through ODH- funded safety nets, primarily the uninsured and those with Medicaid. Safety Net grant applicants must document they are providing care to additional patients to receive an increase in funding from ODH.

2. Additionally, a new HRSA Workforce grant will support two new oral health initiatives: expansion of ODH's School-Based Sealant Program (S-BSP) and creation of a dentist loan repayment program.

• Currently Ohio's S-BSPs apply sealants to the teeth of about 28,000 children each year, 20,000 of which are served by ODH subgrant programs funded with MCH Block Grant funds (three programs are locally funded). The additional HRSA funds will enable ODH to expand the S-BSPs to serve approximately 40,000 students in high-risk schools. The S-BSP Expansion Plan includes a three-pronged approach which consists of

a. Maximizing the reach of the current infrastructure of ODH-funded programs by providing local agencies operating S-BSPs with additional funding to include additional eligible schools within their current area and/or to expand their respective service areas.

b. Funding new agencies to operate S-BSPs in areas, including multi-county, that are not in proximity to existing S-BSPs and have a critical mass of at least 2,000 2nd and 6th grade students enrolled in unserved eligible schools. (see attached map for expansion and areas identified for new programs)

c. Developing new approaches to reach schools that the current infrastructure cannot.

The dentist loan repayment program will be limited to dentists working full-time in federally designated dental Health Professional Shortage Areas (DHPSAs). See map of dental HPSAs. The current Ohio Dentist Loan Repayment Program (ODLRP), funded with a portion of dentist licensure fees, is limited as dentists choose to renew their contracts for 3rd and 4th year funding, allowing a very small number of new applicants to be funded. The timeline for this program is ambitious with dentist contracts starting by 2/1/2011. Additional information will be available on the Oral Health Section's Web page soon
http://www.odh.ohio.gov/odhPrograms/ohs/oral/oral1.aspx.

MCH Priorities 4, 5, 7 and 9 are linked to and addressed through the programs below:

Child Fatality Review (CFR) in Ohio: A Decade of Success
ODH honors the 10th anniversary of the Ohio CFR program which was established in 2000 in response to the need to better understand why children die. By 2002, CFR boards were organized in all 88 counties and began to review the deaths from all causes to children younger than 18. In 2005, Ohio was among the first states to begin using a national Web-based data system developed by the National Center for Child Death Review. In 2009, the Ohio law was changed to specifically protect the confidentiality of CFR data at the state level, allowing ODH staff access to identifying case information that was previously shielded. This change will greatly enhance ODH ability to improve data quality and provide specific technical assistance to counties regarding their data. As of April, 2010, more than 13,000 Ohio reviews had been entered into the data system. The comprehensive nature of the data system allows detailed analysis of the circumstances and factors related to child deaths, which is included in an annual report submitted to the governor and posted on the Internet. The report has drawn national and international interest. Every year, dozens of local initiatives demonstrate that the multidisciplinary review CFR process results in actions to prevent future deaths. Ten years of successful CFR organization, process, collaborations and partnerships will provide a good foundation for the development of FIMRs, PAMRs and prevention initiatives into the next decade.

New Infant Mortality Consortium:
In November 2009 the Ohio Infant Mortality Task Force published its final report containing ten recommendations to lower infant mortality and disparities. The recommendations were developed with input from families and consumers who participated in the task force and provided a large number of comments through an on-line survey. One recommendation was to establish a permanent consortium to carry on with the work. This recommendation resulted in the creation in 2010 of an infant mortality consortium supported by ODH and structured around five workgroups addressing different aspects of the challenge, with oversight by an executive/steering committee. The consortium's work focuses on: Complete and coordinated health care throughout a woman's and child's life; Elimination of disparities in infant mortality and their underlying causes, including racism; Use of evidence-based practice and data to drive decisions; Public education about infant

mortality and ways to decrease it; and Shaping public policy to impact infant mortality and disparities.

Membership consists of a wide array of Ohioans with a high level of interest and expertise in infant and women's health. There exists in the consortium a strong collective will to make changes to significantly improve the health of Ohio's women and infants and reduce the gaps in opportunities for good health between white and black populations. The consortium is off to a good start with the hope and expectation of measurable progress for our citizens in the future.

Regional Perinatal Quality Collaborative redesigns the Regional Perinatal Center Program (RPC): ODH has been working with RPCs for several years to address perinatal quality improvement by stimulating the use of data to identify needs and then implement and evaluate interventions based on current evidence. The Ohio Perinatal Quality Collaborative (OPQC) evolved from these efforts and funding from a neonatal transformation grant helped further develop the collaborative, including setting up a data system and supporting optimal systems of care throughout Ohio. The RPC Coordinators served on the executive and steering committees of OPQC; recruited key stakeholders and families; facilitated regional face-to-face meetings; assisted in learning sessions; and reported progress. ODH is now ready to take this approach to the next step and apply the quality improvement science in a broader way.

ODH will build on the successes of OPQC and the training and technical assistance from national experts such as Kay Johnson and Dr. George Little. In order to further advance these and future projects, ODH plans to partner with Medicaid to focus on improving birth outcomes for the Medicaid population, and arranging Medicaid financing to significantly increase the total investment and establish a broader system of regional quality improvement professionals. ODH, Medicaid and the Ohio Colleges of Medicine Government Resource Center will work with medical schools, hospitals, and local public agencies to recruit and sponsor regional quality improvement professionals and support the implementation and evaluation of quality improvement interventions.

Transitioning to the Healthy Homes and Lead Poisoning Prevention Program:
The Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) has made significant gains toward the goal of eliminating childhood lead poisoning in the State of Ohio. In an effort to continue helping Ohio families have safe and healthy homes, the program is currently transitioning into the Ohio Healthy Homes and Lead Poisoning Prevention Program. (OHHLPPP).With many years of experience completing home environmental assessments and family education, the program is in a strong position to expand its programming to a holistic approach to housing.

Instead of restricting the program's focus to reacting to children who have already been negatively affected by their home environment, OHHLPPP has an ever-increasing focus on primary prevention activities. The primary concepts of a healthy home include keeping it dry, clean, safe, well-ventilated, pest-free, contaminant-free and well-maintained. The health issues related to housing can be reduced or eliminated with proper education, home maintenance, and/or testing.

Ohio is moving in a new direction and is leading the way for other states. Ohio coordinated with the Centers for Disease Control and Prevention (CDC) to acquire the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS). The program will be deploying this new web-based surveillance system in the fall of 2010. By looking at the home as a whole system, the OHHLPPP will better be able to ensure that all Ohioans have access to a healthy and safe home.

MCH Priorities 6 and 8 are primarily addressed in the Bureau for Children with Medical Handicaps by the programs below:

There are many innovative and exciting examples of the Bureau for Children with Medical Handicaps (BCMH) contribution to developing, implementing and maintaining an effective and efficient safety net for Ohio's children with special health care needs. BCMH offers many services that are not consistently covered by other healthcare payers, yet offer a significant return on investment from both a fiscal and health status perspective. BCMH authorizes and provides reimbursement for nutrition consults provided by community dietitians, medication therapy management from a credentialed pharmacist, extended primary care management visits with physicians to support the medical home concept, and public health nurse visits. BCMH's statewide provider network includes hospitals, pharmacies, physicians, allied medical professionals, dentists, durable medical equipment dealers, public health nurses located in the local health departments, disease specific service coordinators located at the tertiary care centers (children's hospitals) and medical supply companies.

This list is not exhaustive, but it gives a sense of the breadth of the system of care that BCMH supports for Ohio's children with special health care needs. Licensed and Registered dietitians provide nutrition consults in the family home. These consults are designed to assess the nutrition status of the child and family and to educate them regarding the role of nutrition in the management of their specific disorder. In the home environment, the dietitian can observe the caregiver mixing a tube feeding, observe the child's eating skills, educate the family on ways to ensure their child receives the optimum nutrition to ensure the child reaches his/her highest levels of development and functioning. The dietitian becomes a key member of the healthcare team. In addition to home visits the dietitian can provide consultative services to the child's school nurse.

BCMH authorizes medication therapy management for clients with a diagnosis of either asthma or diabetes. The specially trained and credentialed pharmacist provides education on the drugs prescribed and any potential interactions, the proper procedures for drug utilization to ensure the client receives the maximum benefit per dose and reviews the pertinent patient history, medication profile (prescription and non-prescription), and recommendations for improving health outcomes and treatment compliance.
In support of the medical home, BCMH pays for extended physician care management care billing codes designed to ensure that physicians are able to spend an appropriate amount of time with children with special health care needs and their caregivers to coordinate needed services. These billing codes afford the physician the opportunity for reimbursement for activities such as extended consultation with other providers, coordination of care among all providers of services and the ability to spend time consulting with the parents, schools or other providers.

Public Health Nurses employed by local health departments serve as a foundation of BCMH's family-centered community based service coordination model. BCMH pays these nurses to educate families and help them enroll on BCMH, Medicaid, Medicare, CHIP and all other potential health care payers. Additionally, these nurses provide training and education on condition-specific issues, help the family navigate the local care delivery system, identify ancillary services that provide value to the family (specialty transportation, skilled respite-care giver, etc). The public health nurses also work closely with the Service Coordinators and Early Intervention Specialists to address the multi needs of the Part C eligible children. These interactions have proven to be positive for the Early Intervention Specialists, the child's physician and the parents.

MCH Priorities 3, 5, 7 and 9 in particular are addressed through the following program, however all programs and priorities are impacted by culturally competent care:

Ohio's Capacity to Provide Culturally Competent Care: Ohio's MCH grantees must complete the Culturally & Linguistically Appropriate Services in Health Care (CLAS) standards self-assessment tool, based on 14 national CLAS standards. DFCHS Cultural Competency Strategy Workgroup assesses races, ethnicities & language of people being served in MCH programs, through a face to face survey process. Findings were drafted, recommendations identified/implementation will occur during FFY11. This infrastructure-level strategy will encompass the following activities: 1) update DFCHS profile of populations served by program, share the collection/reporting of racial/ethnic data, train DFCHS staff on data standards for purpose of improving collection of data on race/ethnicity across programs; 2) incorporate culturally appropriate activities/interventions into DFCHS programs; incorporation of core requirements of cultural competency, based on guidance from National Center for Cultural Competence (NCCC); train ODH staff & local grantees on requirements, for cultural/linguistic competence, & identification of tools to use to monitor progress; 3) development of a Title V program plan that maps out process in moving along continuum to cultural/linguistic competency. Plan will include guidance &/or tools for incorporating cultural/linguistic competence into each of the MCH BG national/state performance measures.

/2012/ ODH continues to focus on the MCH BG overarching priorities created as part of the Five Year Needs Assessment process to: improve the health of children and adolescents (e.g., obesity, STD, oral health, decreasing deaths, improving health outcomes); increase positive pregnancy outcomes and preconception health (e.g., decrease infant mortality and decrease premature births) and system improvements.

SSDI funds were used to enhance ODH's analytic capacity by contracting with statisticians from The Ohio State University College of Public Health. Their skills were used to design and weight ODH surveys on Oral Health/BMI in 3rd graders, School Nurses, and Vision and Hearing Screening. Data from these surveys were analyzed by program researchers and MCH epidemiologists at ODH and are used to inform block grant performance measures and priority areas, and program planning.

ODH is the lead agency for the Maternal, Infant& Early Childhood Home Visiting program. As the lead agency, ODH has collaborated with the required state agencies as well as the OFCF and Ohio's FCAC in preparing the grant applications, Partnered with CWRU to do an analysis of many MCH indicators that not only was used to identify the highest risk counties for HV, but also will be useful in our ongoing assessment of statewide MCH needs & planning. As a state that is participating in the Pew Charitable Trust Home Visiting Initiative, Ohio has benefited from the procurement of a very active HV advocacy group. The Ohio Partnership for strengthening families to address the broad early childhood agenda and the Ohio Partnership has been invaluable in working with the Ohio Legislature to secure funding for the statewide home visiting program -- Help Me Grow. The MIECHV grant has allowed us to plan for significant enhancements to Ohio's system of home visiting. In addition, we have held stakeholder meetings that include child advocacy & service provider representatives to inform decisions made relative to selecting communities at risk & coordination that may be enhanced by the MIECHV funding.

ODH has selected 8 counties for initial implementation of MIECHV. Each county will target a smaller at-risk community & select the home visiting model & provider that will best meet the needs of the community. Providers will work with model developers to assure that services delivered meet fidelity standards of the model & are culturally appropriate for the family.

Another initiative in support of the MCH BG priorities, "Project LAUNCH for Appalachian Ohio" is a federal grant from the Substance Abuse and Mental Health Services Administration, to ODH. It's administered by ODH and implemented in collaboration with local and state partners; a robust Council of State agencies, provider organizations & University faculty.
Project LAUNCH is designed to improve the health and wellness of children ages 0-8 and their families in a four county area in Appalachian Ohio. . Expected outcomes of the project include: innovation in integrating behavioral health & primary care in three settings using different models. Using quality improvement science to transform pediatric primary care practices by using structured developmental assessment tools, (e.g., ASQ, ASQS/E, MCHAT, Edinburg & Family Navigator).

The Bureau of Community Health Services (BCHS) School Nursing Program is piloting a Medication Administration Training for School Personnel. This training has been developed in

response to House Bill 1, and a change in school law regarding the administration of prescription medication (3313.713), effective July 1, 2011 requiring all school employees administering prescription medications in schools to be licensed health professionals or be trained by a licensed health professional.
School and Adolescent Health staff is working with ODH General Counsel to finalize posting of a BMI Rule, a requirement of Ohio's Healthy Choices legislation. The rule must be finalized before the end of the 2011 school year. In March 2011, ODH released the 2004-2010 Third Grade BMI Report, a comprehensive account of state and county level overweight and obesity prevalence among Ohio's third graders. The data in this report will allow ODH to more effectively address the needs of the most vulnerable communities in Ohio, the full report can be found at www.odh.ohio.gov/ASSETS/.../BMI%20Report2011.pdf .

The Oral Health Section's School-based Sealant Programs (S-BSPS) Expansion Plan was developed to increase sealant prevalence as an evidence-based community disease prevention program that provides dental sealants without cost to students in participating schools. The goal of the expansion plan is to apply quality dental sealants in an efficient manner to the maximum number of Ohio's schoolchildren at higher risk for dental caries by targeting schools with high rates of eligibility for the Free and Reduced Price Meal Program. BCHS, through its Primary Care and Rural Health Section, is assisting with implementation of the Patient Centered Medical Home (PCMH) Education Pilot Project enabling 44 primary care practices (40 physicians and 4 APN) in Ohio to implement the PCMH model began in February. Additionally, the Primary Care Office is leading efforts statewide to plan for increasing the capacity of Ohio's primary care workforce.

Within the Bureau of Child & Family Health Services (BCFHS) the Ohio Gestational Diabetes Mellitus (GDM) Collaborative was formed in 2010 and aims to increase the number of women who receive post partum screening and education for type 2diabetes so health risks are addressed early and effectively. The group has focused on a provider survey and focus groups of women with a history of GDM, and used social media (Facebook, Twitter) to promote GDM specific messages. More targeted messaging will be developed based on the final results of the patient focus groups and the provider surveys.

Funded by the Agency for Healthcare Research and Quality, The Ohio Pregnancy-Associated Mortality Review (PAMR) is focused on developing a plan to address maternal mortality and disparities in Ohio. Stakeholders have been engaged and two meetings held (organizational and case review). Members of the PAMR Board encompass a variety of disciplines (e.g., social work, anesthesia, critical care, emergency medicine, risk management, maternal fetal medicine, public health and epidemiology). The newly named Reproductive Health and Wellness Program (RHWP) and combines the Family Planning, Women's Health Services and the family planning component of the Child and Family Health Services Programs into one grant program in order to comprehensively address issues of reproductive health and wellness and continue to focus on populations in greatest need and address identified priorities.

The Ohio General Assembly passed a law (HB 102) in 2010 for expectant parents to receive standardized, objective information about umbilical cord blood banking by making ODH downloadable publications available to health professionals who provide health care services that are directly related to a women's pregnancy.
The Ohio HHLPPP has been awarded 2.1 million dollars for three years by the U.S. Department of Housing and Urban Development to do lead-hazard control work in Ohio. This funding will allow ODH to assist 200 property owners residing in 36 counties to control the lead hazards in their properties, provide weatherization services; and make homes "healthy" by addressing multiple hazards in the home.

The Title V program is a collaborator working with the Office of Health Transformation's Early Childhood and Child Health Care Coordination initiative. This initiative is focused on the review of existing care coordination efforts, and creating a framework that can be used to reorganize and restructure care coordination services to avoid duplication of efforts, while providing coordinated care that will link Ohio's children and families with appropriate medical, mental/behavioral health and social services. Through the Bureau for Children with Medical Handicapps (BCMH) its Genetics and Infant Hearing staff collaborated on a survey of Ohio pediatric audiologists regarding their knowledge of the relationship between infant hearing loss and genetic conditions. Respondents have requested more information about genetics. The tracking of referrals to genetic centers for young children with hearing loss will be initiated in the coming year to help develop next steps.

The ODH Cancer Genetics Network, comprised of ODH Cancer and Genetics staff, and local providers across the state, developed a statement to all Ohioans about "Direct to Consumer Marketing of Genetic Tests". The statement provides accurate, state of the art information about technology, genetic testing and genetics discrimination law and is widely distributed across Ohio and posted to the BCMH Genetics webpage. Staff from the Ohio Connections for Children with Special Needs (OCCSN) partnered with staff from the Michigan birth defects information system to jointly pilot preconception health education materials for women of Arabic descent. Due to the small population, materials were piloted in both states in public health women's health clinics. Products included low literacy/culturally sensitive materials for patients and an online learning module for nurses. //2012//

***/2013/ Ohio WIC implemented Nutrition Education kiosks in statewide WIC clinics as a means for low-risk WIC participants to engage in "self-service" on-line nutrition education. Providing low-risk participants with the opportunity to use the kiosks for nutrition education allows the health professionals to spend more time counseling and educating high-risk participants presenting serious nutrition-related health and medical issues. Upon implementation of the kiosks, Ohio's use of the wichealth.org nutrition education website nearly tripled from the previous year. Ohio WIC began use of the ODH's immunization registry, ImpactSIIS, in local clinics; ImpactSIIS provides local staff with an accurate, efficient tool to determine if children are up-to-date on their immunizations. A small number of WIC clinics piloted use of ImpactSIIS for approximately six months; during the pilot phase, local WIC staff entered more than 17,000 vaccination doses into ImpactSIIS.***

***Ohio's breastfeeding peer helper program was expanded statewide in 2011 to include all local WIC projects, employing a total of 195 breastfeeding peer helpers. Ohio is seeing results, as our "ever breastfed" rates continue to improve, and our exclusively breastfed rates at 3 and 6 months are significantly higher than the national rates.***

***The Bureau of Community Health Services underwent an organizational restructuring and has been renamed the Bureau of Community Health Services and Patient-Centered Primary Care (BCHSPCPC). The Bureau has continued responsibility for managing the functions of the Oral Health Program, Primary Care and Rural Health Program, and School and Adolescent Health Program. In addition, the BCHSPCPC has expanded responsibilities related to statewide health care systems transformation and implementation of the Patient-Centered Medical Home (PCMH) model of care. Those responsibilities include staffing and administration of the Ohio Patient-Centered Primary Care Collaborative (OPCPCC) and its leadership, the OPCPCC Coordinating Council. The Bureau is also responsible for implementation of the Patient-Centered Medical Home Education Pilot Project, a statewide 50 practice PCMH transformation effort, as well as staffing and administrative support to the Education Advisory Group (EAG) that oversees this pilot work.***

***ODH's approach to assuring access to health care has been evolving over the last several years from ODH staff directly providing the care, to affecting the systems of health care. Due to this shift in care, the BCFHS Medical Specialty Services program will no longer be providing direct care services for hearing and vision care after June 30, 2012. For SFY 2013, the Medical Specialty Clinic Program will reimburse select health departments,***

***through contractual agreements, to coordinate and facilitate access to pediatric hearing and vision services for children through June 30, 2013. Financial support of the ODH Medical Specialty Clinic Program will end June 30, 2013. ODH staff will continue to provide technical assistance to local agencies as needed for developing and maintaining sustainable models. While this transition may have an acute and immediate impact on access to care in some communities, this restructuring and consolidation will be a positive step forward in redirecting efforts to helping assure access to quality care without potential duplication of service; focus on informing, educating and empowering people about health issues; and working with our partners, both public and private, to assure that people in communities are linked to hearing and vision services.***

***OCLPPP should be changed to Ohio Healthy Homes and Lead Poisoning Prevention Program (OHHLPPP) to reflect our name change.***

***In December 2011, as part of an internal restructuring plan to promote optimal integration of systems serving children with a broad range of special needs, Ohio's Bureau for Children with Medical Handicaps merged with the Bureau of Early Intervention Services (Help Me Grow Part C Early Intervention, Help Me Grow Home Visiting Programs, and Infant Hearing). This significant organizational change is consistent with the broad definition of CYSHCN and will expand the reach of and coordination between these programs. This merger will improve coordination between a medical model, home based/family centered early intervention and early childhood system leading to a more seamless system for families which will promote health as well as social, emotional and developmental well-being. //2013//***

## C. Organizational Structure

Section III C. Agency Organization

The Ohio Department of Health (ODH) is designated as the State agency responsible for administration of the Title V Maternal and Child Health Block Grant (MCH BG). Alvin D. Jackson, M.D., became director of the Ohio Department of Health (ODH) June 4, 2007, following his appointment by Governor Ted Strickland in January. Director Jackson is one of 26 directors or appointees who serve at the pleasure of Governor Strickland, who is currently in the 4th year of his 1st term as Governor of Ohio.

ODH is organized by Divisions and Offices, Offices report to Director Jackson, while all three Divisions at ODH are under the supervision of Michele Shipp, MD, MPH, PH.D. Prior to joining ODH in 2008, Dr. Shipp was Research Assistant Professor, Division of Health Behavior and Health Promotion in the Ohio State University College of Public Health. The Title V MCH BG is administered out of the Division of Family and Community Health Services (DFCHS), the table of organization for DFCHS is attached to this document, and can be found at www.odhorgchart.odh.ohio.gov/OPE/WebApp/Modules/Chart/Chart.aspx. The MCH BG funded programs and positions are under the supervision of Karen Hughes, MPH, Ohio Title V Director, Chief of DFCHS.

Primary responsibility for MCH programs, under the Direction of the Chief of DFCHS:
Bureau for Children with Medical Handicaps (BCMH) administers programs that serve Children with Special Health Care Needs (CSHCN): including a Diagnostic, Treatment, and Hospital Based Service Coordination Program, supporting Team Based Service Coordination for conditions such as Spina Bifida and Hemophilia; Community Based Service Coordination, supporting Public Health Nurses in the Local Health Departments who assist families in linking to local resources and helping families navigate the health care system; Medical Home for CSHCN, supporting the efforts of local physicians to be Medical Homes for CSHCN. BCMH also houses programs specializing in Genetics which include: Genetic centers, that provide comprehensive care and services to people affected with, or at risk for genetic disorders. Genetic services

include, but are not limited to genetic counseling, education, diagnosis and treatment for all genetic conditions and congenital abnormalities. Sickle Cell Services Program, Metabolic Formula, and Birth Defects Information System.

BCMH utilizes vital committees/council structure to foster open dialogue, receive input and feedback in regards to CSHCN needs across the state the committees are: Medical Advisory Council (MAC) -- members appointed by the Director of Health. The members represent various geographic areas of Ohio, medical disciplines and treatment facilities involved in the treatment of children with medically handicapping conditions; Parent Advisory Committee (PAC) -- composed of parents from around the state who meet regularly to advise BCMH. The mission of PAC is to assure that family-centered care is an essential component in the development and delivery of programs and services for CSHCN; Young Adult Advisory Committee (YAAC) composed of youths aged 16 to 24 who are receiving or have received BCMH services. The mission of YAAC is to advise BCMH of issues facing youth as they transition into adult medical and social services; and the Futures Committee who addresses and advises BCMH on issues, policies and procedures that impact the care provided to CSHCN by the local health departments.

Bureau of Child and Family Health Services (BCFHS) is designed as an organized community effort to improve the health status of women and children in Ohio by identifying needs and implementing programs and services to address identified needs. BCFHS goals are accomplished by engaging in a focused, multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholder that serve racial and ethnic groups disproportionately affected by poor health outcomes, including but not limited to, local public health agencies, community health centers, community-based organizations, faith-based organizations, Regional Perinatal Centers, private sector organizations and other public health providers. Programs/initiatives include; Title X Family Planning (FP), infant mortality reduction (including a statewide task force to address infant mortality and disparities), lead poisoning prevention, prenatal tobacco cessation, Save Our Sight Vision Programs, Child Fatality Review and Sudden Infant Death Program. BCFHS receives funds through US EPA to provide environmental risk assessment screening services to women of reproductive age, to include Shaken Baby Syndrome Education Program, College Pregnancy and Parenting Offices Pilot Program, Neonatal Outcomes Improvement Project.

BCFHS also contracts with Cynthia Shellhaas, M.D., MPH to provide medical consultation to BCFHS programs serving reproductive age/pregnant women/children/families. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of OB/GYN.

Bureau of Early Intervention Services (BEIS) the mission of the Bureau of Early Intervention Services is to assure early identification, support and intervention services for young children and families who have or are at risk for developmental delays or disabilities. Assure education and support to families, service providers/personnel and the general public, through evaluation, planning and implementation statewide. BEIS is responsible for the administration of several programs serving young children (primarily birth to 3) and their families: The Help Me Grow program, Universal Newborn Hearing Screening (UNHS) and Infant Hearing Program: [Statutory Authority: 3701.508] OAC 3701-40 requires that every newborn be screened for hearing loss before hospital discharge, the Healthy Child Care Ohio project which provides for health/safety consultation by registered nurses to child care providers; and the Early Childhood Comprehensive Systems project which requires states to develop intersystem coordination of issues related to early care/education, family support/parenting education/medical home, and social/ emotional development of children birth to age 6.

Bureau of Community Health Services (BCHS) works towards providing information, technical assistance, funding and other support to a variety of local partners, that include local health departments, federally qualified health centers (FQHCs), non-dental health care professionals, schools, Early Start/Head Start programs, hospitals, private non-profit agencies and other safety net dental care providers, to improve access to culturally competent health care for Ohio's most vulnerable populations. Programs include; Community Water Fluoridation (community education and consultation), School-based dental sealant programs, a significant source of grants to safety net dental clinics improves access to dental health care through the OPTIONS Program (Ohio Partnership to Improve Oral Health through access to Needed Services). The program links uninsured/low income patients with safety net dental programs, or a network of dentists who agree to either donate or significantly discount their fees.

Additional sections in BCHS are: Primary Care and Rural Health programs, and School and Adolescent Health. BCHS also contributes content expertise in the area of Medicaid and emergency preparedness planning efforts to meet the needs of populations served by safety net health providers. BCHS is responsible for several major programs; the Primary Care Office (PCO) funded by a cooperative agreement with the HRSA, works to identify unmet needs for primary care by assisting communities in acquiring designation as federal Health Professional Shortage Areas and Medically Underserved Areas/Populations. The School and Adolescent Health (SAH) section promotes the health and safety of the school-aged and adolescent populations in Ohio through data collection, resource development, technical assistance, and training of approximately 1200 school nurses through regional continuing education and professional development opportunities throughout Ohio. Primary Care/Rural Health Program (PC/RH) provides funding for primary care services for uninsured populations of children/pregnant women, places health care providers via 7 placement programs in underserved areas. As of May 2010, Ohio has 140 health providers participating in state or federal loan repayment/scholarship programs (79 primary care, 33 mental health, and 28 oral health). There are 96 Federal National Health Service Corps and 44 State administered loan repayment programs. The recent federal health reform legislation greatly expanded the capacity of FQHCs as well as increased funding for the National Health Service Corps to address health care provider shortages. BCHS also manages the Black Lung Disease Program.

Bureau of Nutrition Services (BNS) responsible for administration of the USDA funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as a Farmer's Market Nutrition program. The Ohio WIC program provides highly nutritious foods, breastfeeding education and support, immunization screening, health care referrals through local agencies to eligible individuals. WIC helps income-eligible pregnant/postpartum/breastfeeding women/infants/children who are at special risk with respect to physical and mental health due to inadequate nutrition, health care, or both. WIC works collaboratively on Title V initiatives for improving the health status of pregnant and breastfeeding women, infants/young children.

Title V Support in the ODH Office of Healthy OhioThe Office of Healthy Ohio is led by Deputy Director Nan Migliozzi, a key component of Governor Strickland's comprehensive health care reform initiative. The Healthy Ohio goal is to improve the health of all Ohioans to create a better quality of life, assure a more productive workforce and equip students for learning, while also contributing to the more efficient and cost-effective use of medical services. Within the Office of Healthy Ohio is the Bureau of Infection Control, the Immunization Unit, the Injury Prevention Program, the Bureau of Health Promotion, Risk Reduction serves as lead for injury programming, the ODH Laboratory, responsible for Newborn Metabolic Screening and follow up, and the Bureau of Health Promotion/Risk Reduction is part of the Office of Healthy Ohio. The Healthy Ohio's Women's Health Program (WHP) receives MCH BG funding for 3 part time staff positions and various women's health activities. The Title V program coordinates with the areas described above to implement MCH BG strategies related to immunization, deaths due to motor vehicle crashes, and women's health issues, including domestic violence activities. The Title V program coordinates activities with the Office of Healthy Ohio related to primary/secondary prevention of chronic diseases (e.g., asthma, diabetes, heart disease) in school settings. A joint collaborative of Prevention and MCH was formed to become the Childhood Obesity Committee. School nurses have access to the Office of Healthy Ohio immunization registry/associated training to prevent school absence due to immunization non-compliance. Over the last year the MCH funded work of school nursing/school health collaborated with Healthy Ohio in planning educational training and materials for Asthma/Diabetes/Pandemic Flu.

The Office of Performance Improvement oversees the Center for Public Health Statistics and Informatics (CPHSI) is a centralized area responsible for the collection, analysis, dissemination and use of health data and provides support to MCH programs, Needs Assessment and the MCH BG. CPHSI allows MCH programs to easily access and integrate volumes of data and information for use in effective decision making. The State System Development Initiative (SSDI) and Pregnancy Risk Assessment Monitoring System (PRAMS) are administered by CPHSI.

The State Epidemiology Office (SEO) uses epidemiology to protect and optimize the health of Ohioans by guiding epidemiologic priorities and activities for the state; coordinating and collaborating with local, state and federal partners; building epidemiologic capacity; and assisting with the translation and reporting of epidemiologic findings and the application of those findings to public health programs and policies in Ohio. It is composed of a state epidemiologist, and senior state epidemiologists for MCH, chronic disease, infectious disease, and environmental health as well as interns and fellows. It supports Title V priorities directly through data analyses, reports, presentations and indirectly through MCH epidemiology strategic planning and capacity building and coordination efforts with other program areas. The state MCH epidemiologist has successfully recruited fellows and interns to address Title V priorities and has engaged CDC EIS officers in MCH work.

/2012/ On November 2, 2010 John Kasich was elected the new Governor of the State of Ohio. In January the governor established an Executive Order creating the Office of Health Transformation (OHT), & named Greg Moody as its Director. Mr Moody's expertise includes 20 years of experience working with Medicaid program design & cost containment. In the next six months OHT will set clear expectations for overall health system performance & recommend a permanent HHS organizational structure & oversee transition to that permanent structure.

On January 13, 2011, Governor Kasich appointed Dr. Theodore (Ted) Wymyslo as the new Director of the Ohio Department of Health. Dr. Wymyslo has 30 years of experience in primary care as a practicing family physician, educator & administrator. Most recently, he has been a strong advocate for implementing the patient-centered medical home model (PCMH) of care in Ohio.

Chief Operating Officer Steve Wermuth, joined ODH on January 31, 2011. Mr. Wermuth has nearly 30 years of experience in health care & has spent more than 15 years in public health. He will be a great asset to Title V in advocating to advance public health. The MCH BG is administered out of DFCHS at ODH, under the supervision of Mr. Wermuth. The MCH BG programs & positions remain under the supervision of Karen Hughes Ohio Title V Director, Chief of DFCHS. Table of Org attached. //2012//

***/2013/ ODH is a cabinet level agency that reports to the Governor's Office, a total of 1,235 employees work for ODH. Of the 1,235 employees 1,009 work in the ODH central office located in Columbus, Ohio and 226 work in the field at district offices located across Ohio. House Bill 487 legislative language requires ODH to refocus its efforts at the local level. ODH has appointed an executive-level leader to oversee these activities and to interact with local health departments to further strengthen our relationship. Martin Tremmel will assume the duties of Deputy Director of Local Public Health Services and oversee the Office of Public Health Support. Martin will report directly to the Director to work with OH's local health partners to redesign the public health system in Ohio. As a prior county health commissioner, Mr. Tremmel's well-established relationship with local health departments and his keen leadership skills make him the most qualified person to represent ODH through this process. Will McHugh will assume the role of Chief Administrative Officer for the agency. As Chief of the Division of Prevention, Will has proven his ability to lead a multitude of programs. Will's duties will include oversight of***

***the three program divisions and the Office of Performance Improvement. ODH will be hiring a Chief Policy Advisor that will report directly to the director. //2013//***
***An attachment is included in this section. IIIC - Organizational Structure***

## D. Other MCH Capacity

Over 200 positions within ODH are either fully or partially supported by the MCH Block Grant (MCH BG); 179 are currently filled. Seventeen of these positions are housed in ODH District Offices; 162 are Central Office positions, based in Columbus.

Division of Family and Community Health Services
Karen F. Hughes
Division Chief
Education: B.S. Education; R.D.H.; M.P.H.
Experience: 15 years BCFHS Chief. Division Chief since February 2006.
Duties: Establish policy, standards and guidelines for the MCH programs and staff; directs the development of program budgets and resource allocations; reviews legislation impacting the MCH program and population served; integrates MCH program objectives with other ODH programs and State agencies; manages the daily operation of the Division. Works with private and public agencies to implement and improve science in children's health programs through BEACON Council (e.g., Ohio Perinatal Quality Collaborative, Solutions for Patient Safety in Children's Hospitals). Also collaborates with outside partners such as March of Dimes and AMCHP to increase efficiencies and improve services.

Bureau for Children with Medical Handicaps
Karen F. Hughes
Interim, Bureau Chief
Education: B.S. Education; R.D.H.; M.P.H.
Experience: 15 years BCFHS Chief. Division Chief since February 2006.
With the retirement of Dr. James Bryant on July 30, 2010, Karen Hughes has assumes responsibility for this Bureau until a replacement for Dr. Bryant can be hired.
Duties: Develop standards, implement programs and direct the CSHCN program; supervise state CSHCN personnel; serve on appropriate boards and advisory groups including Ohio Developmental Disabilities Planning Council; serve on state and federal committees dealing with CSHCN issues. Chair of ODH IRB committee.

The BCMH employs a Parent Advocate, Kathy Bachmann, who works closely with the BCMH Parent Advisory Council and is involved in all Bureau decision making. Ms Bachmann works as a liaison, between families, the Parent Advisory Committee (PAC), Young Adult Advisory Committee (YAAC), and BCMH, providing programming information to families, and brings the family perspective to BCMH Program leadership. BCMH has developed regional youth advisory councils which advise the Bureau on how to address the transition from youth to young adult. In addition, the BEIS provides funding through Part C of IDEA to establish family support activities within the Help Me Grow (Birth to Three Program).

Division of Family and Community Health Services
Sue A Wolfe
Assistant Division Chief
Education: B.S. in Education; RDH; MA Public Administration
Experience: 10 years in Human Resources/Labor Relations/Workforce Development; 10 years in direct service and supervision in health related programs.
Duties: Coordinates projects that span across bureaus and assists programs in the initiation of policies and procedures to ensure the consistent development and implementation of MCH programs across the division. Directs the development of division responses to special assignments, correspondence, and administrative/policy issues. Participates in interagency work to coordinate MCH with other state services. Develops budgets, oversees development of state

and federal grant applications for continuation programs and new initiatives consistent with Division and Departmental priorities.

Theresa Seagraves is the Maternal Child Health (MCH) Block Grant (BG) and Quality Improvement Coordinator, and serves as the data contact for all MCH BG issues and reports to the DFCHS Assistant Chief. With the retirement of Ruth Schrock in June of 2009, Ms. Seagraves came to the Ohio Department of Health on April 12, 2010 with over 20 years experience working in the health/mental health-care arena with a background in social work. Ms. Seagraves' primary responsibilities evolve around the development of statewide policies and procedures regarding the collection, analysis, and reporting of maternal, child and infant health data within the Division of Family and Child Health Services (DFCHS). Additional duties include coordinating the MCH BG application and Needs Assessment, and assisting with the integration of program activities among the State Epidemiology Office (SEO) and the Center for Public Health Statistics and Informatics (CPHSI).

Elizabeth Conrey, Ph.D., was assigned to the ODH by the Center for Disease Control (CDC) and Prevention, Division of Reproductive Health's Maternal and Child Health Epidemiology program. Dr. Conrey is a registered dietitian with a doctorate in community nutrition and an epidemiology minor from Cornell University. As a CDC assignee to the ODH, Dr. Conrey serves as the state's MCH Epidemiologist. Her duties revolve around capacity building in ODH MCH epidemiological studies. The State Epidemiology Office reports to the ODH Assistant Director for Programs. The office includes a senior-level core epidemiology team that meets federal recommendations specifically from the Centers for Disease Control and Prevention [CDC] and the Council for State and Territorial Epidemiologists [CSTE]. This structure optimizes organizational synergy by encouraging better coordination of epidemiologic activities across the agency and across the state. Elizabeth Conrey, ODH's MCH Epi (CDC Assignee) was included in the State Epidemiology Office and was named the Deputy State Epidemiologist for MCH.

Under the State System Development Initiative Grant (SSDI) ODH has been successful in maintaining data sharing agreements with the Ohio Medicaid agency and the Ohio Hospital Association (OHA) and a number of MCH analyses have been completed using these data sources. This initiative is currently being managed by Bill Ramsini, SSDI Project Coordinator. ODH is awaiting approval to transfer those responsibilities to Connie Geidenberger, Ph.D., Chief, Maternal and Child Health Epidemiology due to Mr. Ramsini's retirement in August.

Bureau of Child and Family Health Services
Jo Bouchard, Bureau Chief
Education: B.S. Health Care Mgmt., R.D.H., M.P.H.
Experience: 25 years public health experience, including 4 years Chief; 4 years Assistant Chief; 6 years as Health Planning Administrator, BCFHS; 10 years in program administrator supervisory positions in Bureau of Oral Health Services; 1 year dental public health, Greene Co. Combined Health District.
Duties: Formulates and directs implementation of policies, procedures, goals and objectives for multiple MCH statewide programs in BCFHS. Programs include: Child and Family Health Services; Family Planning; Women's Health Services; Ohio Infant Mortality Reduction Initiative; Prenatal Smoking Cessation; Regional Perinatal Centers Program; Infant Mortality Consortium; Ohio Childhood Lead Poisoning Prevention; Save Our Sight; Pediatric Specialty Medical Clinics (Hearing, Vision); Child Fatality Review; Sudden Infant Death (SID); Shaken Baby Syndrome Education; Pregnancy Associated Mortality Review; Gestational Diabetes Mellitus and Chronic Disease Integration; Acts as Demobilization Unit Leader in Ohio Incident Command System.

Bureau of Community Health Services
Mark Siegal
Bureau Chief
Education: D.D.S.; M.P.H.; Certificate in Pediatric Dentistry; Certificate in Dental Public Health; Diplomat of the American Board of Dental Public Health and a past-president of the Ohio

Academy of Pediatric Dentistry.
Experience: 23 years Chief; 2 years Columbus City Health Department Dental Director; 4 years Hospital Director for Pediatric Dental Services; 4 years New Mexico Health District Dental Director.
Duties: Directs the Bureau of Community Health Services activities toward improving the oral health of Ohioans by assessing needs, implementing community-based disease prevention and health promotion and increasing access to dental care. Maintains a liaison role with professional associations and other agencies on policy development and other collaborative efforts. Acts as a Planning Section Chief in the Ohio Incident Command System. Directs the assessment, planning, implementation, policy development and evaluation of statewide programs including the offices of Primary Care and Rural Health (including 6 health care provider recruitment and retention programs), Black Lung, School and Adolescent Health Services, and collaborative initiatives to improve health care access for underserved populations.

Bureau of Early Intervention Services
Sondra Crayton
Acting Bureau Chief
Education: BA, History, MA, Political Science, MA, Psychology, PhD, Psychology
Experience: 9 months, Acting Bureau Chief, 5.5 years experience as Assistant Bureau Chief, 6 years experience as Operations Manager at a local Family & Children First Council, 8 years as Adjunct Professor at The Ohio State University's School of Social Work
Duties: Directs the planning, development, implementation and evaluation of Bureau programs which focus on families with infants and toddlers (Help Me Grow program including Part C IDEA and Home Visiting services for at risk infants and toddlers; Infant Hearing Screening program; and Healthy Child Care Ohio program); and coordinating interagency efforts around a state plan for Early Childhood systems which address medical home, family support, parent education and social-emotional development of young children.

Bureau of Nutrition Services
Michele A. Frizzell
Bureau Chief
Education: BS in Dietetics; Registered Dietitian; Master in Business Administration
Effective April 4, 2005, Michele Frizzell is Chief of the Bureau of Nutrition Services. Experience: Over 25 years of diverse public service experience, most recently at the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), where she managed the quality improvement initiatives for a number of ODADAS statewide programs. For the ten years prior to her work at ODADAS, she held a number of positions in the ODH WIC Program, including program consultant, administrator of program support, and system redesign project manager.

/2012/ Due to the retirements of James Bryant, MD., on July 30, 2010, Mark Siegal, DDS, on October 30, 2010 and MCH BG Parent Advocate Kathy Bachmann on February 28, 2011, the following changes have occurred.

Bureau for Children with Medical Handicaps
Dr. Jessica Foster
Bureau Chief
Education: MD from the University of Kansas, School of Medicine where she also completed her fellowship training. MPH from the University of Kansas.
Experience: Dr. Foster comes to ODH from Nationwide Children's Hospital where she practiced as a developmental pediatrician with a focus on children with special health care needs. Her practice was integrated with the constellation of physicians and many disciplines of health care providers that serve children with special health care needs. She has been active in initiatives to promote systems of care including early developmental screening and early intervention. Additionally, Dr. Foster served as a LEND (Leadership Education in Neurodevelopmental &

Related Disabilities) faculty member at the Nisonger Center at The Ohio State University.
Duties: Develop standards, implement programs and direct the CSHCN program; supervise state CSHCN personnel; serve on appropriate boards and advisory groups including Ohio Developmental Disabilities Planning Council; serve on state and federal committees dealing with CSHCN issues.

The BCMH is in the process of hiring a Parent Advocate, who will continue to work closely with the BCMH Parent Advisory Council (PAC), have input into Bureau decision making work as a liaison to the PAC, Young Adult Advisory Committee (YAAC), Part C early Intervention Advisory Council, Early Childhood Advisory Council, and provide programming information to families, and bring the family perspective to Title V Program leadership. Under the direction of the new CSHCN Director, the role & function of the Parent Advocate will be revised to be more inclusive of all children with special health care needs in Ohio. The Title V program will recruit & hire following the redefinition of the position.

Bureau of Community Health Services
Heather Reed
Acting Bureau Chief
Education: Bachelor of Science degree in Psychology at the Ohio State University in 1988 and a Master's in Community Health Education in 1991. Ms Reed has begun coursework towards her Ph.D. in Rural Sociology at OSU.
Experience: Prior to accepting the Program Administrator position Heather served as the Rural Health Section Administrator since January, 2000. In that capacity she administered the State Office of Rural Health Grant Program (SORH), State Rural Hospital Flex Grant Program (SRHF), Small Rural Hospital Improvement Grant Program (SHIP), Black Lung Clinics Program, the Appalachian Healthy Living Initiative, Uninsured Care Program, and Medical Liability Insurance Reimbursement Program. Heather was the Coordinator of the SORH beginning in 1991. She is an active member of the National Rural Health Association (NRHA) as well as a published co-author in the NRHA publication The Journal of Rural Health.
Duties: Oversees multiple statewide programs, including Oral Health Services, School & Adolescent Health Services, and the Primary Care and Rural Health Program. Serves as Administrator of the Primary Care and Rural Health Program, a position she accepted in September of 2007 and that includes several state and federally funded initiatives targeted towards strengthening health care systems and ensuring an adequate health care workforce in Ohio's rural and urban underserved communities. //2012//

***/2013/ Several significant changes have occurred in the Division of Family and Community Health Services (DFCHS) since our last Block Grant application.***

***Sue A Wolfe, Assistant Division Chief retired from state service on April 30, 2012. The Assistant Division Chief position will be replaced in the next SFY.***

***Heather Reed was named Chief of the Bureau of Community Health Services and Patient-Centered Primary Care, effective Monday, April 23, 2012. Heather had been serving in the Acting role since December 2010. She demonstrated strong leadership in the past year and a half as the Bureau had undergone many changes, and in working closely with the Director as the Ohio Department of Health (ODH) works to transform the health care delivery system in Ohio by increasing the number of patient-centered medical homes statewide.***

***Heather has been with the agency since July of 1990 and served in several different capacities, including the state's first Rural Health Coordinator, the Rural Health Section Administrator, and the Primary Care and Rural Health Program Administrator. Heather has developed a national reputation as a leader in rural health policy development, having***

***served as President of the Board of the National Organization of State Offices of Rural Health as well as a member of the National Advisory Committee on Rural Health and Human Services, a 21 member advisory board to the Secretary of the Department of Health and Human Services.***

***Kimberly Weimer accepted a position with ODH as the BCMH Parent Consultant effective 9/26/2011. Kim is the mother of Kailey, a beautiful 19 year old young woman, who has special health care needs. Kim has numerous years of experience working with families and children.  Previously she has been a Family Support Specialist for Franklin County Help Me Grow.  In her most recent position, she has served as the Early Childhood Resource Network Family Support and equipment loan manager. Kim has been a member of the BCMH Parent Advisory Committee and serves as the AMCHP Ohio Title V Family Delegate.  Kim has also served on numerous statewide/BCMH workgroups and committees. Kim worked with BCMH on various medical home initiatives and has started and facilitated numerous parent support groups.***

***Kim's interest includes transition activities for young adults, assuring that all families have access to the resources they need to help them access services for their child and representing the needs of families as BCMH addresses the many aspects of healthcare reform.***

***Ohio was fortunate to have an opportunity to work with Dr. Arthur James. In 2011, Dr. James moved to Columbus, Ohio to join the faculty of the Ohio State University Department of Obstetrics & Gynecology and University Medical Center as the leader of their effort to eliminate disparities in health care for women and infants in Central Ohio. He also assumed the roles of Ohio Better Birth Outcomes coordinator with Nationwide Children's Hospital in Columbus, Senior Policy Advisor to the Ohio Department of Health, and Co-chair of the Ohio Collaborative to Prevent Infant Mortality. Dr. James comes well-equipped to lead Ohio's charge to eliminate infant mortality and health disparities based on his successful community-based effort in Kalamazoo County, Michigan that reduced African-American infant mortality from 29.7 to 3.2 deaths per 1,000 births. //2013//***
***An attachment is included in this section. IIID - Other MCH Capacity***

## E. State Agency Coordination

The Ohio Title V Program, administered within the ODH, has strong collaborative relationships with other state agencies, local health departments (LHD), local public heath agencies, academic programs/professional associations to improve the health of the MCH and CSHCN population.

Executive Level State Collaboration
Ohio Family and Children First (OFCF): OFCF is a collaborative effort of the state's education, health, and social service systems with Ohio families, concentrated on achieving the shared policy goal of ensuring that all children are safe, healthy and ready to learn. The partnership is critical because no single state system has the resources or capacity to meet this goal alone. Oversight of the initiative is provided by the OFCF Cabinet Council which include agency directors of; Ohio Department of Education (ODE), Ohio Department of Alcohol and Drug Addiction Services (ODADAS), Office of Budget Management (OBM), Ohio Department of Health (ODH), Ohio Department of Jobs and Family Services (ODJFS), Ohio Department of Mental Health (ODMH), Ohio Department of Developmental Disabilities (DODD), ODA, and Ohio Department of Youth Services (ODYS). The DFCHS Chief serves on the OFCF Deputies Committee to ensure a system-wide implementation of all OFCF priorities and activities. DFCHS data staff serves on the OFCF Data Committee to develop a set of child well-being indicators. Each of Ohio's 88 counties has created an OFCF Council,council membership includes families, representatives of public agencies, schools, courts and private providers. Each council is responsible for determining local strategies to achieve school readiness and address a shared commitment to child well-being which include.

BEACON
Ohio's Medicaid leadership has joined with the Ohio's Title V MCH Program to convene children's health care partners to form the BEACON Council. The aim of the Best Evidence for Advancing Childhealth in Ohio NOW (BEACON) initiative is to achieve transformational change in health outcomes for children by improving the quality of their healthcare. Through the systematic and reliable application of established improvement science methods and by building strong partnerships with key stakeholders, Ohio's statewide collaboration will achieve unprecedented results for birth and developmental/behavioral health outcomes and safe hospital care for children. Simultaneously, BEACON will establish a sustainable infrastructure for improvement capability.

In 2009 Governor Ted Strickland requested that the ODH establish a task force to study and report on infant mortality and disparities. A group of about 70 individuals made up the task force, co-chaired by Thomas G. Breitenback, CEO of Premier Health Partners, Inc., and ODH Director Alvin D. Jackson, MD. Membership represented a wide range of public and private health providers, businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. In November 2009, the Ohio Infant Mortality Task Force issued its final report which provided extensive background information and included ten recommendations. The complete task force report, including involved organizations is available at http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx
The task force recommended the creation of an ongoing consortium to continue its work, and the ODH BCFHS is facilitating the development of this consortium. A small executive/steering committee is now being formed to develop the leadership and committee structure as well as bylaws. Later, members will be recruited for specialized committees. Once organized, the yet-to-be-named consortium will likely create a plan to promote implementation of the recommendations, search for funding, and prepare annual progress reports for the Governor.

The DFCHS Chief and BCFHS Chief serve on the Executive Council of the Cleveland Healthy Family/Healthy Start federal project to reduce infant mortality and have been actively involved with this project throughout its history. Both also serve on the Executive Council of the Columbus Healthy Start Project and participated in developing the coordination proposal submitted to MCHB.

The Primary Care/Rural Health (PCRH) program has taken the lead for 2 Presidential Initiatives in Ohio: development/expansion of FQHCs, and growth of the National Health Service Corps (NHSC). A coordinated effort is underway with Ohio Association of Community Health Centers (OACHC) to develop FQHCs in medically underserved areas. NHSC Scholarship and Loan Repayment Programs assist in staffing Ohio FQHCs as well as other safety net provider sites located in underserved areas. Ohio Rural Development Partnership (ORDP) developed a 501c3 organization, Ohio Rural Partners (ORP), which is able to apply for and receive federal/foundation/other funding. With the passage of the current biennial budget in July 2009, the administration of the OPDP Advisory Committee was transferred successfully from the Ohio Board of Regents to ODH. The BCMH Chief is the governor's appointed representative of ODH and Chair on the Ohio Physician Loan Repayment advisory committee which selects applicants who are practicing in underserved parts of Ohio to receive loan repayments funded with money collected with medical license renewals.

ODJFS develops and oversees programs that provide health care, employment and economic assistance, child support, and services to families and children, and administers the Medicaid program. ODH's Title V program has the following MCH/CSHCN-related interagency agreements with ODJFS: 1) Title V and Title XIX links services for the purpose of coordinating health services, conducting outreach, program eligibility and payment for services for mothers and children as defined and specified in 42 USC section 701, et. al., and 7 CFR Part 246. The agreement coordinates the exchange of information and referral among the local Child and Family Health Services projects (CFHS), WIC, Help Me Grow (HMG), Ryan White programs, Offices of Primary

Care and Rural Health (PCRH), and the Ohio Medicaid programs, 2) environmental lead risk assessment done in homes of Medicaid-eligible children with blood lead levels (BBL) > or equal to 10 ug/dL; 3) agreement reimbursing ODH for costs associated with the development of brochures/materials, and training on communicable diseases/first aid/medicationadministration/back-to-sleep/developmental screening/inclusive child care as part of a health/safety training curriculum for child care providers/ trainers, 4) a statewide immunization and MMIS interface creates interface between ODJFS & ODH to share immunization records and sharing of blood lead screening on Medicaid-eligible children & other lead related information. This agreement will provide Medicaid funds for development of a new lead poisoning surveillance system, 5) agreement between ODJFS and ODH for the conduct of desk reviews/interim settlements/field audits/and final settlements for ODH's BCMH. The agreement meets the requirements of Title V for financial accountability and administration of BCMH, 6) inter-agency agreement provides funding for an annual training session required for members of Child Fatality Review Boards (CFR). BCFHS coordinates with the ODJFS Children's Trust Fund Board on activities related to the CFR program; 7) data sharing and research projects of mutual interest related to the administration of Medicaid and the State Children's Health Insurance Program produced information needed for MCH policy decisions.

ODH and ODJFS work together to assist in implementation/coordination of the Ohio mandated Medicaid Managed Care Program. ODH worked with ODJFS Medicaid and Managed Care Plan personnel to implement managed care contracts between the plans/health agencies.

ODJFS participates with ODH Perinatal Data Use Consortium. ODH entered into an interagency agreement with ODJFS to provide support to the Ohio Perinatal Quality Collaborative (OPQC). Most support is provided by the Regional Perinatal Center Program facilitating local access for quality improvement initiatives. ODH in collaboration with ODJFS are addressing poor pregnancy outcomes through a CMS sponsored transformation effort involving a partnership of state agencies, neonatal/obstetrical providers, professional organizations and a center with expertise in quality improvement. This effort has already demonstrated substantial improvements in perinatal outcomes. OPQC's first obstetrics project achieved a statistically significant 70% reduction (12.5% to 4%) in the rate of scheduled late preterm deliveries without medical indication, and a reduction in NICU-associated, bacterial, bloodstream ifnrect8ins in preterm infants 22-29 weeks gestational age by 40% (20% to 12%)

An agreement between the Social Security Administration (SSA) and ODH establishes conditions under which SSA agrees to disclose information related to eligibility for and payment of Social Security benefits and/or supplemental security income and special veterans benefits, including certain tax return information to ODH for use in verifying income/eligibility.

An interagency steering committee (including parents, private organizations, and nine state agencies) co-chaired by ODADAS, ODH, and DODD, guides the Ohio Fetal Alcohol Spectrum Disorders (FASD) initiative through components including primary/secondary prevention services, education and regional parent networking. The charge to the steering committee is to integrate FASD activities in state/local agencies through existing programs/systems, not relying on dedicated funding. Through the partnership, a state website was launched, www.notasingledrop.org which provides information about FASD to health care professionals, families and the general public. The steering committee has partnered, with the Ohio Center for Autism and Low Incidence (OCALI) to promote FASD education and FASD is a featured topic on the OCALI website at: http://www.ocali.org  The state's FASD initiative continues to work to prevent alcohol-exposed pregnancies and improve screening, diagnosis and services referrals for those affected by prenatal alcohol exposure.

The DFCHS Chief serves on the ODJFS Children's Trust Fund Board; ODH coordinates with the Trust Fund on activities related to the CFR program, including preparation and publishing of the CFR annual state report.

ODE receives TA and training by DFCHS nutrition/oral health/ nursing/hearing/vision consultants to state Head Start Programs in collaboration with Ohio Head Start Association, Inc. (OHSAI) and ODE. At the request of OHSAI and ODE, Division of Early Childhood Education, a state Head Start/WIC agreement designed to promote collaboration between the 2 programs in the areas of nutrition screening, assessment, education, referral, and recruitment was signed.

Specific Bureau Related Collaboration
Bureau of Early Intervention Services (BEIS) collaborates with the ODJFS Bureau of Child Care and the Child Care Resource and Referral Association to expand the network of child care health consultants (RNs) to provide health/safety information to licensed child care providers. The ODH Healthy Child Care Ohio coordinator serves as an ex-offico member on the ODJFS Day Care Advisory Council, a legislatively mandated body that advises ODJFS on child care policy and implementation of child care law. The HMG program in BEIS collaborates with the Part B Special Education and 619 (Preschool programs at ODE to assure that training and information to local programs and school districts are coordinated where necessary. There is an agreement between ODH and DODD to assist DODD staff that provide TA to local county boards concerning Help Me Grow.

An agreement between ODH and DODD confirms their intent to assist jointly in comprehensive planning/coordination for a statewide HMG system to include infants/toddlers with developmental delays/disabilities, as defined in Part C of the Individuals with Disabilities Act, and their families. DFCHS staff serves on several interagency committees including the Ohio Autism Taskforce which was staffed by DODD.

Collaboration with ODMH happens on 2 levels; BEIS is working closely with the early childhood mental health initiative (MHI) at ODMH on projects addressing early identification and referral of new mothers with postpartum depression and young children with potential social/emotional needs; and training providers on ways to work with families with young children with challenging behavior, training is provided by ODMH. BCHS continues to work on school based MHIs by representing the school nurse perspective and has co-sponsored a statewide strategic planning session to develop a plan for increasing school based mental health programs in Ohio schools. Currently there are 4 pilot programs in 4 area school districts using the "Columbia Teen Screen"/Depression Screening Program.

Bureau of Community Health Services (BCHS) provides TA to approximately 1,200 school nurses as they assist families/students to access primary care/mental health/ dental health safety net services identified by the Primary Care Program to address unmet health care needs and to eliminate health disparities.

BCHS School and Adolescent Health (SAH) program helps ODE improve nutrition messages for school aged children/families/teachers with the expertise of a public health nutritionist funded by the MCH BG. The SAH program works with randomly selected local school districts to administer the YRBS. In collaboration with the Ohio Chapter of the American Cancer Society, SAH administers the Governor's Buckeye Best School awards program which recognizes schools for achievements in the areas of increasing physical activity, improving nutrition and preventing tobacco use. The school nursing supervisor in SAH worked collaboratively with ODE special education services to revise rules for providing clinical services to students with special health care needs. SAH collaborated with ODE to write a grant application to CDC that funds support for YRBS, Coordinated School Health and HIV education. The SAH is working with the ODE on implementing the CDC Coordinated School Health (CSH) grant. The CSH grant has resulted in an MOU with ODE which funds one full time equivalent (FTE) to function as the project coordinator for ODH. SAH is providing technical assistance and training to school districts and ODH funded agencies promoting school health using the CSH framework. The SAH program works collaboratively to promote school healthy with the Ohio School Based Health Center Association and Ohio Action for Healthy Children by participating on the Board of Directors of both agencies.

PCRH staff collaborated with the State Refugee Coordinator at ODJFS to submit a Refugee Preventive Health grant application to provide infrastructure building and enabling services to improve health screening and medical follow up within 90 days of refugees' arrival in the US.

Bureau of Nutrition Services (BNS) continues coordination with the Ohio Department of Rehabilitation and Correction (ODRC) for the Prison Nursery Program. BNS continues its coordination with the Ohio Environmental Protection Agency (OEPA) for the annual Sport Fish Consumption Advisory. BCHS works with OEPA to maintain current information on the fluoride status of community water systems. Ohio EPA continues to participate on the Ohio Lead Advisory Council.

ODE sits on the ODH Lead Advisory Council, which is adding requirements for child care's school facilities to ensure lead safe environments.

An ODH representative from the OCLPPP serves as an appointed steering committee member of the Greater Cleveland Lead Advisory Council.

Other Professional and Medical Collaboration
The ODH Title V Program works closely with related professional medical organizations through staff participation on numerous advisory boards/committees, and shares some committees with organizations.

Ohio Hospital Association (OHA): OHA is the membership/advocacy organization for Ohio's hospitals. OHA has developed a strong interest in its small/and rural hospitals, and has created a Small/ Rural Hospital Committee. In addition, OHA partnered with the State Office of Rural Health (SORH) in the development/implementation of the State Rural Hospital Flexibility Grant Program that enabled Ohio to designate Critical Access Hospitals (CAHs). Early in the development of this Program an advisory committee was created, with representation from OHA, the SORH, rural hospitals, the OACHC, the Ohio State Health Network, Division of EMS, ORDP, and others with an interest in strengthening the rural health infrastructure. The Flex Advisory Board meets quarterly; since its inception this meeting has been hosted by OHA. A total of 34 small rural hospitals have achieved CAH designation in Ohio. There is a memorandum of understanding for data sharing between ODH and OHA. ODH developed an agency agenda for data needed from OHA for research/reporting purposes and has received and analyzed OHA data. ODH staff is currently analyzing hospitalization data dealing with ambulatory sensitive conditions to determine potential access to care issues across Ohio.

Ohio Association of Children's Hospitals (OACH): BCMH collaborates closely with OACH. The Association is a key member of the MCH Advisory Counsel, the Birth Defects Advisory Council, and serves on other advisory groups as requested. OACH is a key partner/advocate for health care issues for all children, especially CSHCN.

Ohio Chapter/American Academy of Pediatrics (OC/AAP): OC/AAP shares the Children with Disabilities Subcommittee with the BCMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social/educational issues of CSHCN in addition to medical issues. The DFCHS participates with the OC/AAP in development of a long term strategic plan targeting mental health concerns for children/adolescents. The BCHS works with OC/AAP and American Council of Family Practitioners to develop oral health training for physicians/ pediatricians.

Ohio Section of ACOG: The DFCHS Chief attends Ohio ACOG quarterly meetings to share information from ODH. Ohio ACOG and other diverse groups are members of the Family Planning (FP) Advisory Council and the FP State-Wide Needs Assessment Stakeholders Workgroup.

Ohio Dental Association (ODA): BCHS partners with ODA to administer a statewide volunteer dental care program called Dental OPTIONS (Ohio Partnership To Improve Oral health through access to Needed Services). This dental referral/case management program matches clients with dentists who provide discounted or donated care in their offices.

Ohio Head Start Association, Inc. (OHSAI): BNS has an interagency agreement with OHSAI for the purpose of program coordination. BCHS collaborates closely with the OHSAI and convenes the Head Start Oral Health Steering Committee on a regular basis. Among other agencies/organizations on this group are ODJFS, ODH BEIS, State Head Start Collaboration Office, Ohio Academy of Pediatric Dentistry, ODA, and numerous local groups.

Health Policy Institute of Ohio (HPIO): BCHS collaborates with HPIO to convene the Dental Workforce Roundtable, with representatives from dental schools, organized dentistry, dental hygiene and dental expanded functions: state dental board, PCA, and Association of Ohio Health Commissioners. BCHS is actively represented on Ohio Coalition for Oral Health, with LHDs, FQHCs, and OACHC.

Ohio Public Health Association (OPHA): BCHS assumed the lead to work with OPHA Directors of Nursing Section and Ohio Nurses Foundation (ONF) to develop 17 web based continuing education modules in support of public health nurse (PHN) workforce development. Eight of the modules were based on competencies developed by the Council on Linkages Between Academia and Public Health Practice. Five of the modules were designed for school nurses; 4 were designed to meet the learning needs of PHNs who supervise a new health care provider role in Ohio, Community Health Worker. All of the modules can be accessed at www.publichealthnurses.com. The OPHA Directors of Nursing section discussed using the 8 updated competency based modules as prerequisites for the quarterly PHN orientation content presented by ODH. All 17 modules will move to a website supported by the ONF.

Ohio Lead Advisory Council (OLAC):  In addition to appointed members from ODJFS/ODE/OEPA, these organizations also have members who serve on the OLAC: Ohio Department of Development, Apartment Owner's Association, Help End Lead Poisoning Coalition, Environmental Health Association, National Paint and Coatings Association, and other nonprofit/public health agencies outside of the appointed membership.

ODH (BCFHS) will partner with the department of obstetrics and gynecology at The Ohio State University College of Medicine (OSU-COM), which has been named as a recipient of Agency for Healthcare Research and Quality funds, to develop a state-wide Pregnancy Associated Mortality Review (PAMR) system in Ohio.  Pregnancy-associated mortality review (PAMR) is a perfect illustration of a process where a focus on patient safety and prevention of adverse events would lead to improvements in both healthcare system operations and clinical care.  This would, in turn, decrease the potential for medical liability claims. Ohio is one of 5 states that will work with the National Universal Vision Screening for Young Children Coordinating Center.

This National Center will promote and ensure a continuum of eye care for young children within the healthcare system.  Ohio Coalition member include the Ohio Departments of Education and Job and Family Services (Medicaid) as well as professional organizations such as the Ohio Chapter of the American Academy of Pediatrics, Ohio Academy of Family Physicians and National Association of Pediatric Nurse Practitioners.  ODH is a co-chair of this Coalition and Karen Hughes is serving on the national advisory panel as the title V representative for this project.

/2012/ The Ohio Department of Job and Family Services (ODJFS) Office of Ohio Health Plans (OHP) and the Ohio Department of Health (ODH), Division of Family and Community Health Services (DFCHS) work jointly with the BEACON Council and the Council of Medical Deans, Ohio Colleges of Medicine Government Resource Center (GRC) to design and direct healthcare quality improvement initiatives for Ohio's Medicaid covered families, women and children.

With a focus of improving; quality, outcomes, and reducing costs, the projects that have been targeted by the BEACON Council and viewed as important to MCH: the Developmental & Autism Screening Project, which aims to measurably improve outcomes for young children in Ohio through the identification, evaluation, referral and treatment of children at risk for or with delayed development, autism, and social/emotional concerns; the Ohio Perinatal Quality Collaborative (OPQC) whose aim is to reduce preterm births and improve outcomes of preterm newborns as quickly as possible; the Childhood Obesity Project, which partners with the Ohio chapters of the AAP and the Ohio Children's Hospital Association to implement screening and care processes in primary care settings that promote healthy activity and nutrition; Solutions for Patient Safety (SPS) that involves all 8 children's hospitals in Ohio participating in a project to improve outcomes in surgical site infections and medication safety. This project is funded by Cardinal Health and the Ohio Business Roundtable and so far has resulted in a 60% reduction in surgical site infections in designated procedures and a 34.5% reduction in overall adverse drug events; and the Pediatric Psychiatry Network (PPN) which provides primary care physicians throughout Ohio access to psychiatric consultation through a toll-free telephone number 24/7 for child and adolescent psychiatry decision support, education and triage services to help diagnose and treat patients with psychiatric issues.

At the Quality of Care Measurement Conference hosted by the BEACON Council on February 8, 2011, additional priority areas titled "Hotspots" for Medicaid costs & outcomes were identified and are now under development as BEACON Council projects. The priority areas focus on: avoidable hospital admissions and use of emergency rooms for children with Asthma; the Mental Health System, with a particular priority on care coordination for high cost children and their use of medications; and the creation of "Health Homes" for the Aged, Blind and Disabled (ABD) children with an emphasis on developing a system of coordinated care.

BCMH is working in collaboration with the "Act Early" Ohio team, a statewide coalition of University programs, state agencies, community organizations and advocacy groups, in a national network of state "Act Early" teams to share resources, best practices, and opportunities for families and children with autism spectrum disorders, and related developmental disabilities in the identification, assessment, diagnosis and interventions areas. //2012//

***/2013/ The Patient-Centered Medical Home (PCMH) and health care systems transformation work occurring in the BCHSPCPC has led to several new partnerships as well as expansions of existing partnerships. Renewed collaboration with many of the agencies that are part of the Office of Health Transformation (OHT) on integration and care coordination activities have occurred, especially with the Office of Medicaid and the Ohio Department of Mental Health. Additionally, work with provider associations such as the Ohio Academy of Family Physicians (OAFP), Ohio Chapter of the American Academy of Pediatrics (AAP), and the Ohio Osteopathic Association (OOA) has intensified. The PCMH work has also led to the establishment of a relationship with the Ohio Board of Regents (BOR).***

***Ohio's Title V CYSHCN program worked collaboratively with the Ohio Department of Job and Family Services and the Ohio Department of Mental Health to fund and develop the Children's Mental Health Learning Collaborative. This project is supported by Ohio Colleges of Medicine Government Resource Center and is being led by the Ohio Chapter of the American Academy of Pediatrics. The project targets primary care practices, with a focus on Medicaid, to improve the delivery of children's mental health services in primary care, while integrating resources from Ohio's Pediatric Psychiatry Network (PPN). The project will promote healthy social and emotional development and mental health in two developmental stages of childhood: birth to age 6 and ages 7 to 18. Resiliency and positive management of stress, if developed from infancy onward, will impact outcomes in health, mental health, and social and emotional wellness across the life course.***

***"Ohio Statewide System of Services for Early Intervention: Bridging the Gaps in Ohio Part C Service Delivery", a project sponsored by Ohio's DD Council. This project is using telehealth technology to engage families, Help Me Grow service providers and primary care providers in early intervention services, promoting improved coordination of systems and the medical home model. Leaders from the combined Bureau have worked collaboratively as members of the Early Childhood and Child Health Care Coordination Team which was convened by the Ohio Office of Health Transformation. The group developed a statement of strategic direction regarding the future of care coordination, developed desired attributes of a system and planned an early childhood care coordination pilot project. This project will utilize the HUB/Pathways model of care coordination and will be piloted in Southeast Ohio in the region where Project LAUNCH is underway. //2013//***

## F. Health Systems Capacity Indicators

In light of the new guidance from HRSA which indicates States may select one, some, or all health status indicators to discuss in the narrative section Ohio selected the HSI's below. These particular indicators were choosen primarily because they relate to MCH block grant activity that ODH have determined to be priority. The selections were made through a two-step process.

The selections were made through a two-step process. First, indicators with direct relevance to a state or national performance measure were identified. From those, indicators related to one of the 9 identified block grant priorities (i.e., HSCI 09B is related to "Decrease rate of smoking for pregnant women, young women and parents" and HSCI 08 is related to "Increase successful transition of special needs children from pediatric/adolescent to adult health care systems"), or if an indicator related to the statewide efforts of the Ohio Collaborative to Prevent Infant Mortality (i.e., HSCI 04).

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Health System Capacity Measure 04 : The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected number of prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index
Narrative:
The 2010 Vital Statistics Birth Records indicate that 71.8 percent of women aged 15 through 44 received 80 percent or more of their expected prenatal care visits as measured on the Kotelchuck Index. The mean age of women receiving their care was 28 years. There was a statistically significant difference in the mean age of mothers attending 80 percent or greater of their prenatal visits and those who attended less than 80 percent, with mean ages of 26 and 28 years, respectively and a p-value $<0.0001$.

A racial disparity existed among those women receiving 80 percent of their expected prenatal care, with black women being 1.2 times less likely to receive their care versus white women, with 60.9 percent of black women and 74.7 percent of white women. Hispanic women are also 1.2 times less likely to attend 80 percent of their expected prenatal visits than Non-Hispanic women.

Mothers whose delivery was paid for by Medicaid were slightly less likely to attend 80 percent or greater prenatal visits, with 66.4 percent of Medicaid mothers versus 75.6 percent of Non-Medicaid mothers.
73.5 percent of mothers with low birth weight infants received 80 percent or greater of their expected prenatal care while 71.7 percent of mothers with normal birth weight infants obtained the expected prenatal care. Mothers of very low birth weight infants were even more likely than mothers of normal birth weight infants to access 80 percent or greater prenatal care with 76.3 percent and 71.8 percent respectively. Mothers of preterm infants were slightly more likely to receive 80 percent of their expected prenatal care with 73.6 percent versus 71.5 percent of mothers of full term infants.

The Kotelchuck Index relies on the month of initiation of prenatal care as recorded within the birth certificate. In 2010 22.7 percent of births had no information recorded in this field. The large proportion of missing information affects the validity of the Kotelchuck measures and should be considered when interpreting these results.

Health System Capacity Measure 08:
Narrative: The Ohio Department of Health (ODH), Bureau for Children with Medical Handicaps and Early Intervention Services (BCMHEIS) works with the regional SSI office to determine numbers for this indicator. The denominator is representative of the children in the Ohio less than 16 years old that are receiving SSI Supplemental Security in the state. This is state specific data. The numerator is the number of children that are receiving services from the BCMHEIS program that the program was able to match with the SSI recipients.

BCMHEIS was successful in obtaining a data match with the local SSI data repository located at the Ohio Department of Job and Family Services (ODJFS). As stated above, BCMHEIS works with the regional SSI office to determine compliance with this indicator. BCMHEIS encourages families of children enrolled in the various programs to apply for SSI, if their child is eligible for SSI. BCMH continues its aggressive educational program with 117 local health departments (LHD) that provide public health nursing services. The LHD employ 315 public health nurses statewide to coordinate services for children enrolled in the BCMHEIS CSHCN program. The PHN coordinates referrals to Early Intervention, WIC, local ODJFS and SSI, etc. BCMHEIS provides annual updates related to SSI determination process to the local PHNs at regional meetings held semiannually in 5 regions of the State.

BCMHEI also actively works with the Ohio Department of Rehabilitative Services (ODRS) who is charged with determining the eligibility of the child for SSI benefits. ODRS sends all children approved for services to the BCMHEIS program. BCMHEIS performs a match to children currently on the program. If the child is not known to the BCMHEIS, the staff generates a letter to the parents to inform them of the program eligibility and services that their child may be eligible to receive. In addition, the parents are provided the name and phone number for the local public health nurse.

Health System Capacity Measure 09B:
The YTS is used in planning programs relating to youth tobacco use prevention. Data have been collected on prevalence of use of tobacco products, exposure to secondhand smoke, knowledge, attitudes, and beliefs about tobacco use, and susceptibility to tobacco use among middle and high school students since 2000. The latest available data are from 2010. In 2010, 9.4 percent of middle school students were current tobacco users, compared with 26.1 percent of high school students.

***An attachment is included in this section. IIIF - Health Systems Capacity Indicators***

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

The Division of Family and Community Health Services (DFCHS) provided stakeholders participating in the Needs Assessment prioritization process with a compilation of quantitative data specific to their population group. The data were primarily organized into topic areas in a fact sheet format. Data sources included state and national Vital Statistics, PRAMS, Youth Risk Behavior Survey (YRBS), www.cdc.gov/nccdphp/dash/yrbs/index.htm, Behavioral Risk Factor Surveillance Survey (BRFSS), www.cdc.gov/brfss/technical_infodata/surveydata.htm, Ohio Family Health Survey (OFHS), http://grc.osu.edu.ofhs, Census, Disease Surveillance and ODH program statistics.

To begin the discussion of health issues, participants reviewed a compiled list of health care issues gathered from a separate stakeholder survey conducted by ODH. This information was sought from practitioners and providers across Ohio and provided a local perspective to the issues for each sub-population. Stakeholders generated a list of recurring themes within these local stakeholder survey results. This list was used as a reference point throughout the needs assessment process. Several of the highest priority health issues cut across more than one sub-population. These cross cutting issues are:

- Access to Care (inclusive of all population groups), including immunizations
- Parent education and support (early childhood, school-age, special needs)
- Birth outcomes/child mortality (women's health, early childhood, special needs)
- Intentional and unintentional injury (inclusive of all population groups)
- Early identification through screening (early childhood, school-age, special needs)
- Disparities in health outcomes (women's health, early childhood, special needs)
- Chronic conditions (school age, special needs), including mental illness, diabetes, substance abuse, asthma, obesity/overweight, sensory deficits and developmental delays

A final prioritization of the identified issues produced the states 9 priorities and subsequent 10 state performance measures.

STATE PERFORMANCE MEASUREs

1. Statewide capacity to reduce unintended pregnancies among populations at risk for poor birth outcomes.
2. Percentage of low birth weight black births among all live black births.
3. Percent of local health departments that provide health education and/or health services in schools.
4. Degree to which DFCHS programs can incorporate and evaluate culturally appropriate activities and interventions
5. Percent of 3rd graders who are overweight.
6. Development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and evaluate preconception health effects.
7. Percent of 3rd graders with untreated caries.
8. Adolescent deaths (age 10-24) due to intentional and unintentional injuries.
9. Maintenance/enhancement of Ohio Connections for Children with Special Needs (OCCSN) BDIS (birth defect registry) to improve utilization of data of surveillance, referrals to services and prevention activities.
10. Percent of children who receive timely, age-appropriate screening and referral.

## B. State Priorities

The state has identified the following concerns regarding access to MCH health care and health-related services. The needs assessment process incorporated data required to measure the MCH Block Grant performance and outcome measures and the health status indicators that were being developed by the federal MCH Bureau. The priority areas of greatest concern are organized below by the four levels of the pyramid, and the overall programming strengths and weakness for each population group are outlined at the end of each section.

• Women's Health, Birth Outcomes and Newborn Health

Issues to consider:

o Health behaviors (nutrition, physical activity, substance use, oral health, breastfeeding)
o Well woman care (preconception and interconception care)
o Sexual behaviors and their consequences (unintended pregnancy, STDS, teen pregnancy, family planning/pregnancy prevention)
o Pre-natal/post-partum care
o Neonatal care (1st visit, specialist follow up, car seats, back to sleep/safe sleep, shaken baby)
o Breastfeeding
o Mental health
o Safety (safety belts, abuse/violence, living environment)
o Chronic disease prevention, treatment and management
o Educational attainment

Strengths and Weaknesses

Currently, Ohio's economy has played a major role in the deficits associated with women and infant health and birth outcomes. The diminishing financial support and revenue sources have helped to erode local program funding or prevented programming from expanding state-wide. Diminished financial support has also contributed to a lack of adequate prenatal care providers. Another weakness has been the lack of available contraceptive services for teens due to the expense of the newer contraceptive methods, and resistance in Ohio for schools to fully address use of contraceptives. In regards to an overall perspective, some of the trends surrounding programming activities have not been fully investigated in order to identify impact, strengthens or weaknesses.

Although, programming weaknesses can be found, Ohio has numerous strengths that have aided MCH programs in weathering the current economic environment. ODH continues to strengthen its collaborative efforts with other state agencies, which promotes the sharing of data, information, and the combining of resources. Additional supplemental funds from Title X have helped to strengthen ODH's capacity to meet MCH needs. In 2009 the charge was given to ODH to create the Ohio Infant Mortality Task Force to address disparities in infant mortality in Ohio's African American community. In 2010, ODH collaborated with Columbus Public Health on the Infant Mortality and Racism Action Learning Collaborative. Additional strengths for women and infant health, is that Ohio has a single breastfeeding coalition and adoption of breastfeeding in the workplace by the Ohio Obesity Plan. In alignment with national performance measure 18, Medicaid has a mandated performance indicator that addresses access to prenatal care for women in their first trimester.

• Early Childhood, School-age, Adolescents and Young Adults

Issues to consider:

o Risky behaviors including substance use (including tobacco and alcohol), risky sexual behavior, truancy and their consequences
o Referral to services then diagnosis and treatment (hearing, vision, mental/social-emotional, oral, lead, nutrition, obesity/overweight, early childhood development, asthma, trauma)
o Inadequate and inappropriate nutrition and physical activity resulting in obesity,

overweight and nutritional deficiencies
o Early care and education (systems approach including all birth to kindergarten services)
o Health, wellness and social development (life skills) are not identified as a part of school achievement
o Safe and supportive environments (schools, neighborhoods) including environmental exposures
o Breastfeeding sustainment

Strengths and Weaknesses
In 2008, 28% of low-income Ohio children aged 2 to 5 years had a BMI at or above the 85th percentile, while 12% were considered to be obese with a BMI at or greater than the 95th percentile. In addition during 2008-2009 18.5% if 3rd graders were obese and 17.4% of third graders were overweight. The data associated with these percentages suggest that low-income Hispanic and Non-Hispanic black 3rd graders were significantly likely to be overweight or obese than non-Hispanic or white children. Although, Ohio is experiencing weaknesses in regards to obesity of its school age children, for its 0 -- 3 age group Ohio's Home Visiting program curricula has had successes with its healthy nutrition programs.

Another area of concern for Ohio is that black and Hispanic children are less likely than white children to have private health insurance. ODH has attempted to convene staff from multiple state agencies to discuss this issue, but was not successful in FFY09. This continues to be an ongoing issue in FFY10, as well as the lack of health insurance coverage for adolescent and young adults transitioning to the adult system for their on-going medical needs.

At the same time, Ohio continues to improve in its capacity to serve the MCH population through efforts like implementing and evaluating programs to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy. Working with Healthy Child Care Ohio in regards to their efforts to increased child care providers competency to manage children's chronic health care needs. Additional strengths include the increase in social and emotional screenings for children in child care, combined with the fact that the overall death rate for students considering suicide have decreased.

Other infrastructure level strategies that strengthen MCH programs are accomplished by working with AMCHP and collaborating with the Ohio Department of Education in an Action Learning Collaborative on: establishing health education in Ohio public schools; distributing supplemental funds to subgrantees to purchase long-acting reversible contraceptives; monitoring funded subgrantees to assure that they utilize best practices; promoting community outreach activities, and assuring that culturally, age, and education-level appropriate information is available to patients, partners and community members; and collaborating with WIC to use a mobile van to provide pregnancy testing, STI testing, treatment and contraception.

Ohio has demonstrated strength in its capacity to meet the needs of the MCH population through its campaign to increase public and professional awareness of early hearing detection and intervention (EHDI) and distributing educational materials to physicians; preparing and disseminating reports for legislators and others; identifying potential areas for collaboration and working with Au.D. programs and medical schools to incorporate EHDI into curriculums. The Infant Hearing Program and the Genetics Program staff continued to explore ways to collaborate. In the Fall of 2009 the staff began to revise the UNHS Follow-up Hearing Evaluation Reporting form and genetics referral was included. A Genetics Counselor regularly attends Help Me Grow (HMG) training to provide an overview of and literature on genetics.

• Children with Special Health Care Needs
Issues to consider:
o Patient/family centered coordinated care
o Appropriate insurance coverage to provide needed services to CSHCN aged 0-24
o Mental, social, behavioral and developmental health issues

- o Transition to all aspects of adult life including adult care
- o Disintegrated administration of the system of care
- o Newborn screening, genetics services

Strengths and Weaknesses
Ohios capacity, is often challenged when it comes to serving children with special health care needs, due to the complexity and specialized nature of the illness. Providers and parents of this population are often dealing with data systems that are not yet integrated. This is a particular weakness for newborn screening labs and other ODH genetics and sickle cell partners. Children's hospitals do not have access to vital statistics Integrated Public Health Information System (IPHIS) to report screening and paper reports are sent to ODH for data entry.

Timelines for reporting this information is specified in regulations so there is often reliance on goodwill and education to improve the timeliness. However, timeliness of reporting; poor coordination and understanding of IPHIS access at the hospital level; a lack of emphasis on comprehensive accurate reporting and self monitoring create an inability of systems to integrate data.

Ohio currently lacks adequately trained pediatric providers in some geographic areas. Due to reduced funding in recent years it has become increasingly harder to recruit and retain clinicians, especially in specific areas such as Appalachia. The lack of family and provider resources not only in Appalachia but rural and inner city areas lends itself to inadequate or decreased trained pediatric providers or require extensive travel. Adding to this is also the lack of central resources (manpower) to provide more outreach and education to audiologist, primary care providers and for general coordination and troubleshooting.

While these issues exist and can appear to be significant, Ohio has developed numerous strengths in meeting the needs of the CSHCN population. ODH staff monitors the reporting that comes in and can identify specific concerns for outreach and education. In addition, ODH approves hospital protocols to ensure compliance with standards, and uniformity across the state and can offer technical assistance to help generate system integration.

A series of facilitated meetings took place by the DFCHS Leadership to discuss and rank the priorities identified by the stakeholder group's. ODH was able to collectively identify the state's 9 critical MCH priority needs. These 9 critical priorities fall within 3 categories; improve the health of children and adolescents; increase positive pregnancy outcomes and preconception; and system improvement.

The FFY11 Ohio Maternal Child Health Block Grant Priorities are:
1) Increase physical activity and improve nutrition;
2) Increase breastfeeding initiation and duration rates;
3) Improve early childhood development;
4) Decrease rate of smoking for pregnant women, young women and parents;
5) Increase the viability of the health care safety net;
6) Increase the number of women, children and adolescents with a health home;
7) Increase access to evidence based community prevention programs;
8) Increase successful transition of special needs children from pediatric/adolescent to adult health care systems;
9) Improve the availability of useful and accurate health care data and information (this relates to quality and capacity).

/2012/ ODH continues to focus on the 9 MCH BG Priorities that were identified in its FFY11 Needs Assessment, the Title V Program goals are to integrate HRSA's Life Course approach, the BEACON rapid quality improvement science model and the state's focus on improving care delivery while reducing cost into the implementation strategies behind its priorities.

The Ohio Maternal Child Health Block Grant Priorities are:
1) Increase physical activity and improve nutrition;
2) Increase breastfeeding initiation and duration rates;
3) Improve early childhood development;
4) Decrease rate of smoking for pregnant women, young women and parents;
5) Increase the viability of the health care safety net;
6) Increase the number of women, children and adolescents with a health home;
7) Increase access to evidence based community prevention programs;
8) Increase successful transition of special needs children from pediatric/adolescent to adult health care systems;
9) Improve the availability of useful and accurate health care data and information (this relates to quality and capacity). //2012//

***/2013/ Ohio continues to focus on its nine priorities with a major emphasis on Infant Mortality. In collaboration with ASTHO and The March of Dimes, the ODH Director has charged the department with focusing on this initative. A recent press release helps to explain why, see attached. //2013//***
***An attachment is included in this section. IVB - State Priorities***

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 27.3 | 27.3 | 3.3 | 100.0 | 100.0 |
| Numerator | 88 | 88 | 8 | 232 | 1430 |
| Denominator | 322 | 322 | 246 | 232 | 1430 |
| Data Source | | ODH Newborn Screening Lab (see notes) | Ohio Newborn Screening Lab (see notes) | ODH Newborn Screening Lab/Genetic Services Data/Me | ODH Newborn Screening Lab/Genetic Services Data/Me |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance | 100 | 100 | 100 | 100 | 100 |

| Objective | | | | | |
|---|---|---|---|---|---|

**Notes - 2010**
Sickle cell and other hemoglobin trait cases are not included in either the numerator or denominator for 2010. The ODH Newborn Screening Lab does not record trait follow up information. The ODH Sickle Cell Program is in process of taking that activity on and hopefully will report these numbers in future years.

Not all comfirmed disorders require treatment so a percentage should not be calculated. Data source: ODH Newborn Screening Lab; Genetic Services Data; Metabolic Formula Program.

Numerator= #newborns confirmed with disorder or confirmed other disorder.

In order to close case w/specific diagnosis, lab reports and/or physicians notes are submitted to the lab. This information is summarized in the notes category of the lab spreadsheet.

**Notes - 2009**
The ODH Newborn Screening Lab is responsible for calling out abnormal newborn screening results and closing the case with diagnostic information. The Lab has been undergoing a major system upgrade for over a year and during this time they are not recording any treatment information. With improvements to the state's genetics and birth defects data systems, we anticipate collecting more complete treatment information in the coming years.

The manufacturer of the MS/MS is the driving force behind the upgrade to the Lab's specimen analysis and associated patient database software systems. This is a comercial product being customized to fit with ODH's system. It has been a multi-year process. In addition to upgrading the system, the system also has to continue to process blood specimens and keep newborn screening running while the upgrade is going on. The ODH Genetics Program developed a data system to collect additional newborn screeing information to assist with reportin for Form 6. This data system was rolled out in late calendar year 2008. We anticipate improved treatment and longer term follow up information beginning with MCHBG submission in July 2011 (birth data from 2009). The numerator is currently: #received treatment. The denominator is:# all confirmed cases. Together this is not a meaningful measure of accomplishment or progress in newborn screening, as not all confirmed cases require treatment.

**a. Last Year's Accomplishments**
The percent of screen positive newborns who receive timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening program.

1. Monitor and reconcile newborn screening cases between the Genetic Center data system, the Metabolic Formula data system, and the ODH Newborn Screening Lab system.

REPORT OF ACCOMPLISHMENTS: All newborn screening cases requiring special formula were reconciled between the NBS Lab, the Genetics data system and the Metabolic Formula data system. Newborn screening cases seen and reported in the Genetics data system were used as a grant monitoring tool. Additional work needs to be done to fully reconcile all appropriate newborn screening lab cases with the genetics data system. This work will continue in FFY2012.

2. Include newborn bloodspot screening diagnoses and diagnoses related to newborn/infant hearing loss in the state's reportable birth defects panel.

REPORT OF ACCOMPLISHMENTS: OAC rules were promulgated that added disorders on Ohio's newborn bloodspot screening panel and disorders related to infant hearing loss to the reportable list of birth.

3. Provide access to the ODH Newborn Screening Lab system to Regional Sickle Cell Projects to close hemoglobin trait cases at their locations.

REPORT OF ACCOMPLISHMENTS: ODH staff received access to the Newborn Screening Lab system in April, 2011. We have not yet rolled out the access to this data system to external partners yet. This activity will be completed in 2012.

4. Participate in the Region 4 Genetics Collaborative.

REPORT OF ACCOMPLISHMENTS: Five ODH staff actively participated in the Region 4 Genetics Collaborative through participation on work groups (Laboratory, CAH, Hemoglobinopathies, Transition, and Access to Genetic Services) and attendance at the regional meeting in Sept. 2011. This is an ongoing activity for Ohio.

5. Work with Medicaid, WIC and BCMH to improve provision of special formulas for children who participate in multiple programs.

REPORT OF ACCOMPLISHMENTS: ODH continues to reach out to Medicaid to improve the provision of special formulas. Issues with individual cases are resolved, but no wide sweeping policy changes to improve conflicting rules and regulations between multiple programs have been implemented. ODH continues to work on this issue.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Monitor and reconcile newborn screening cases between the Genetic Center data system, the Metabolic Formula data system, and the ODH Newborn Screening Lab system. | | | | X |
| 2. Include newborn bloodspot screening diagnoses and diagnoses related to newborn/infant hearing loss in the state's reportable birth defects panel. | | | | X |
| 3. Provide access to the ODH Newborn Screening Lab system to Regional Sickle Cell Projects to close hemoglobin trait cases at their locations. | | | | X |
| 4. Participate in the Region 4 Genetics Collaborative. | | | | X |
| 5. Work with Medicaid, WIC and BCMH to improve provision of special formulas for children who participate in multiple programs. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
NPM 01 Current Activities
Strategies for the Current FFY 10/1/2011 -- 9/30/2012

Strategy A: Monitor and reconcile newborn screening cases between the Genetic Center data system, the Metabolic Formula data system, and the ODH Newborn Screening Lab system.

Strategy B: Include newborn bloodspot screening diagnoses and diagnoses related to newborn/infant hearing loss in the state's reportable birth defects panel.

Strategy C: Provide access to the ODH Newborn Screening Lab system to Regional Sickle Cell Projects to close hemoglobin trait cases at their locations.

Strategy D: Participate in the Region 4 Genetics Collaborative.

Strategy E: Work with Medicaid, WIC and BCMH to improve provision of special formulas for children who participate in multiple programs.

**c. Plan for the Coming Year**
The percent of screen positive newborns who receive timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening program.

Strategies for 10/1/12 -- 09/30/13
1. Prepare report of genetic center cases that match with Newborn Screening Lab cases. Present this information to the Genetic Center Directors.
2. Continue participation in the Region 4 Genetics Collaborative.
3. Explore newborn screening for cardiac defects, and develop plan for ODH's role in assuring universal screening and appropriate follow up.
4. Continue collaboration with Medicaid, WIC and BCMH regarding the provision of special formulas for children who participate in multiple programs.

## Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

| **Total Births by Occurrence:** | **140208** | | | | | |
|---|---|---|---|---|---|---|
| **Reporting Year:** | **2011** | | | | | |
| **Type of Screening Tests:** | **(A) Receiving at least one Screen (1)** | | **(B) No. of Presumptive Positive Screens** | **(C) No. Confirmed Cases (2)** | **(D) Needing Treatment that Received Treatment (3)** | |
| | No. | % | No. | No. | No. | % |
| Phenylketonuria (Classical) | 140208 | 100.0 | 64 | 5 | 5 | 100.0 |
| Congenital Hypothyroidism (Classical) | 140208 | 100.0 | 1057 | 68 | 68 | 100.0 |
| Galactosemia (Classical) | 140208 | 100.0 | 18 | 3 | 3 | 100.0 |
| Sickle Cell Disease | 140208 | 100.0 | 92 | 55 | 55 | 100.0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Biotinidase Deficiency | 140208 | 100.0 | 11 | 2 | 2 | 100.0 |
| Congenital Adrenal Hypoplasia | 140208 | 100.0 | 444 | 8 | 8 | 100.0 |
| Cystic Fibrosis | 140208 | 100.0 | 603 | 39 | 39 | 100.0 |
| Homocystinuria | 140208 | 100.0 | 297 | 0 | 0 | |
| Maple Syrup Urine Disease | 140208 | 100.0 | 19 | 0 | 0 | |
| SCADD | 140208 | 100.0 | 36 | 10 | 10 | 100.0 |
| Very Long-Chain Acyl-CoA Dehydrogenase Deficiency | 140208 | 100.0 | 17 | 2 | 2 | 100.0 |
| Argininemia | 140208 | 100.0 | 35 | 0 | 0 | |
| Citrullinemia | 140208 | 100.0 | 9 | 1 | 1 | 100.0 |
| Isovaleric Acidemia | 140208 | 100.0 | 73 | 2 | 2 | 100.0 |
| Propionic Acidemia | 140208 | 100.0 | 40 | 3 | 3 | 100.0 |
| Carnitine Uptake Defect | 140208 | 100.0 | 19 | 1 | 1 | 100.0 |
| Isobutyryl-CoA Dehydrogenase Deficiency | 140208 | 100.0 | 36 | 1 | 1 | 100.0 |
| Medium-Chain Acyl-CoA Dehydrogenase Deficiency | 140208 | 100.0 | 26 | 15 | 15 | 100.0 |
| Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency | 140208 | 100.0 | 16 | 2 | 2 | 100.0 |
| Carnitine Acylcarnitine | 140208 | 100.0 | 45 | 0 | 0 | |
| Carnitine Palmitoyl | 140208 | 100.0 | 45 | 1 | 1 | 100.0 |

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |
| Annual Indicator | 65.4 | 65.4 | 65.4 | 65.4 | 73.7 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Based on the 2009/10 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percentage of Ohio children with special health care needs age 0 to 18 whose families partnered in decision-making at all levels and were satisfied with the services they received was 73.7% (95% C.I., 69.4%-78.0%). This was slightly higher than the national percentage of 70.3% (95% C.I., 69.4%-71.1%), although the 95% confidence intervals overlapped (National Survey of Children with Special Health Care Needs, 2012). Due to changes in the survey, this result is not comparable to those from previous years.

Statistically significant differences between Ohio and the nation were observed for prescription medicine and service use (Ohio proportion: 84.2%, 95% C.I. 78.4%-90.0%; national proportion: 73.6%; 95% C.I., 71.9%-75.2%), race/ethnicity group of “non-white and non-African-American, non-Hispanic” (Ohio proportion 85.3%, 95% C.I., 76.6%-94.1%; national proportion: 66.8%, C.I., 63.5%-70.1%), the parent respondent having greater than a high school education (Ohio proportion 78.8%, 95% C.I., 74.7%-82.8%; national proportion: 73.3%, C.I., 72.4%-74.2%), children with no (of 14 named) functional difficulties (Ohio proportion 92.5%, 95% C.I., 87.1%-97.9%; national proportion: 84.8%, C.I., 82.6%-87.0%), a household income of 300%-399% of the federal poverty level (Ohio proportion 84.5%, 95% C.I., 76.1%-93.0%; national proportion: 73.3%, C.I., 71.0%-75.6%), and among a two parent biological or adoptive family structure (Ohio proportion: 81.7%; 95% C.I., 77.5%-85.9%; national proportion: 74.0%, 95% C.I., 73.0%-75.1%). If an Ohio strata proportion was lower than the national proportion on this measure, either the 95% C.I. overlapped with the national 95% C.I. or the Ohio cell size was much lower than 50. Analysis for additional statistical significance and trending on this measure will be considered in the future.

Reference:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 05/02/2012 from www.childhealthdata.org.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**a. Last Year's Accomplishments**
Performance Measure 02: The percent of children with special health care needs age 0-18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CYSHCN survey)

1. Empower families to work in partnership with providers in decision making.
BCMH has continued to maintain the BCMH website to include up-to-date information with input from our parent and provider groups. Additionally, BCMH staff, EI staff and the Parent Consultant continue to work with the "Red Treehouse" project. The RedTreehouse.org was developed as a partnership between the Ronald McDonald House of Cleveland, Inc. and Ohio Family and Children First with support from many state and local agencies.

The Red Treehouse is designed to be a welcoming and vibrant online community of resources for Ohio's families and professionals to help children and young adults (prenatal through age 25) meet daily needs, overcome challenges, and develop their fullest potential. This resource, as it rolls out statewide, will link families to local resources including parent trainings and support group meetings.
Ohio participates in the HRSA-funded Region 4 Genetics Collaborative which developed Partnering with Your Doctor: The Medical Home Approach, a guide for families with children with heritable disorders. Ohio distributed hundreds of these documents through networks and meetings.

2. Partner with Family Voices of Ohio, Family to Family Centers to strengthen regional family activities.
Family Voices of Ohio leadership and Family to Family Health Information Specialists have continued to attend BCMH Parent Advisory Council (PAC) meetings. This connection allows for identification of gaps and barriers for families seeking services for their CYSHCN and provides a forum to plan and coordinate efforts related to informing and empowering parents.

3. Link families to 211 and the Benefit Bank.
BCMH continues to facilitate information sharing between our families and stakeholders (Parent Advisory Council, Family Voices, Family to Family Health Information Specialists, public health nurses, and Help Me Grow service coordinators) and the Ohio United Way 2-1-1 Community Resource sites and Ohio Benefit Bank to ensure communication and awareness of services for CYSHCN in Ohio.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Empower families to work in partnership with providers in decision making. | | X | | |
| 2. Partner with Family Voices of Ohio, Family to Family Centers to strengthen regional family activities. | | X | | |
| 3. Link families to 211 and the Benefit Bank. | | X | | |
| 4. | | | | |

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**b. Current Activities**
Performance Measure 02: The percent of children with special health care needs age 0-18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CYSHCN survey)

Strategies for the Current FFY 10/1/2011 -- 9/30/2012:

Strategy A: Empower families to work in partnership with providers in decision making. Began work as the Title V partner on the "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation Grant for CYSHCN which was awarded to Dr. Pam Oatis at Mercy St. Vincent Medical Center in Toledo, Ohio. Initial trainings in the principles and practice of medical home and "Listening with Connection", a communication skill building program, were supported. The trainings began with public health nurses.

Strategy B: Partner with Family Voices of Ohio, Family to Family Centers to strengthen regional family activities.

Strategy C: Link families to 211 and the Benefit Bank.

**c. Plan for the Coming Year**
Performance Measure 02: The percent of children with special health care needs age 0-18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CYSHCN survey)

Empower families to work in partnership with providers in decision making.
1. Our CYSHCN program is the Title V partner on the "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation Grant for CYSHCN which was awarded to Dr. Pam Oatis at Mercy St. Vincent Medical Center in Toledo, Ohio. Together with Dr. Oatis and the grant's third key partner, Family Voices of Ohio, we are providing training in the principles and practice of medical home and "Listening with Connection", a communication skill building program, with a goal to reach 700 direct service providers who can then partner with families in decision making. Trainings on medical home and "Listening with Connection" have started with public health nurses and Family to Family Health Information Specialists. The project will begin to train facilitators. Next year these facilitators will implement the medical home curricula and "Listening with Connection" in local communities with Help Me Grow workers, Children's Hospital Parent Advocacy Committees, school nurses and other target audiences. Finally, we will ensure the medical home training is incorporated into practice by "hard wiring" medical home into the family assessment forms used annually by BCMH public health nurses and also into the Family Voices satisfaction survey.

2. Enhance family partnerships and strengthen regional family activities.
Family Voices of Ohio leadership and Family to Family Health Information Specialists continue to attend our Parent Advisory Council (PAC) meetings. This connection allows for identification of gaps and barriers for families seeking services for their CYSHCN and provides a forum to plan and coordinate efforts related to informing and empowering parents. With our new parent consultant on board, we plan to focus on ensuring a range of special needs and geographical/regional representation on the PAC committee. We plan to "travel" our PAC

meetings throughout the state with the goal of improved community parent engagement. Additionally, as the Title V partner on two HRSA grants within our state, "Ohio Statewide Medical Home Project for CYSHCN" and "REAL Action in Ohio: Resources, Education, Alignment and Linkages", we are connecting the parent leadership from these projects to ensure connection and coordination of these efforts as they reach families of CYSHCN in our state.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 60 | 60 | 60 | 60 | 60 |
| Annual Indicator | 55.6 | 55.6 | 55.6 | 55.6 | 46.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 60 | 60 | 60 | 60 | 60 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
The percent of Ohio children with special health care needs age 0 to 18 who received coordinated, ongoing, comprehensive care within a medical home was 46.4% (95% C.I., 41.8%-51.0%) compared to the national average of 43.0% (95% C.I., 42.1%-43.8%; National Survey of Children with Special Health Care Needs, 2012). All stratum-specific percentages provided by the Data Resource Center for Child and Adolescent Health followed this similar finding. When the State of Ohio's measure was lower than the national percentage, the 95% confidence interval overlapped or the cell size was less than 50, thus having too few respondents for an acceptable

comparison.

This measurement changed only slightly compared to the previous survey (2005/06), so comparisons can be made. In the previous survey, Ohio's proportion on this measure was substantially higher (55.6%, 95% C.I., 51.6%-59.7%) than the national percentage (47.1%, 95% C.I., 46.3%-48.0%) and 95% confidence intervals did not overlap. These findings were also seen in the proportions for 12-17 year-olds (Ohio proportion 56.0%, 95% C.I., 49.7%-62.3%; national proportion 45.2%, 44.0%-46.5%) and males (Ohio proportion 53.5%, 95% C.I., 48.1%-58.8%; national proportion 46.7%, 45.6%-47.8%). Other strata responses were slightly modified, thus limiting the comparisons. Overall, from the previous survey to current, Ohio's performance on this measure has decreased. Analysis for additional statistical significance and trending will be considered to understand how Ohio's performance has changed on this measure.

Reference:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 05/02/2012 from www.childhealthdata.org.
National Survey of Children with Special Health Care Needs. NS-CSHCN 2005/06. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 05/02/2012 from www.childhealthdata.org.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**a. Last Year's Accomplishments**
Performance Measure 03: The percent of children with special health care needs age 0-18 years who receive coordinated, ongoing, comprehensive care within a medical home. (CYSHCN survey)

1. Strengthen medical home, particularly in the area of coordination of services for families and providers.
BCMH has worked to facilitate relevant CYSHCN stakeholder involvement in Ohio's Patient Centered Medical Home Education Pilot Project which selected 44 practices in the state to undergo transformation to Patient Centered Medical Homes. Additionally, BCMH has facilitated CYSHCN stakeholder involvement in the Ohio Patient-Centered Primary Care Collaborative (PCPCC) which is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals working together to support and promote the Patient-Centered Medical Home model of healthcare delivery in Ohio. Finally, the D70 CYSHCN State Implementation grant, "Ohio Statewide Medical Home Project for CYSHCN", was awarded to Dr. Pam Oatis at Mercy St. Vincent in Toledo, Ohio. BCMH is the Title V partner and Family Voices is the third key partner on this grant which will run from 7/1/11 -- 6/31/14.

2. Continue to support Cincinnati Children's Hospital Special Needs Resource Directory.
The BCMH Parent Consultant provided input into this Directory service. The Cincinnati Children's Hospital Special Needs Resource Directory can assist parents, caregivers and healthcare providers to identify, evaluate and access necessary services and supports through connection with local, regional and national websites.

3. Work with the Ohio Chapter of AAP to link to foster care notebook.
BCMH has worked with the OAAP to assure that children in foster care have access to their medical information as they move through the foster care system. BCMH staff provided input into the development of the My Story Book. The "My Story" Foster Care Program is an effort to give Ohio's foster children a voice, and a chance to tell their story. My Story Book is a portable medical record for the individual child. The Ohio AAP and the Ohio AAP Foundation developed this program to address the special social and emotional needs of foster care children and families. The Foster Care Program is currently being piloted in central Ohio with expectations of expanding the program throughout the state. BCMH has provided information about this program to the local public health nurses and has made them aware of resource that can be used to support foster and adopted children in the community.

4. Finalize connection with ODH Bureau of Early Intervention Services medical home autism services.
This project had been placed on hold due to current state wide initiatives related to health homes and health care reform in the last year. Given the continued surge in health home activities at the state level, this work has been folded into the broader health home statewide agenda. Relevant to this work, BCMH continues to work with the state Interagency Workgroup on Autism and can use this partnership to address medical home for autism when appropriate in the future.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Strengthen medical home, particularly in the area of coordination of services for families and providers. | | | | X |
| 2. Continue to support Cincinnati Children’s Hospital Special Needs Resource Directory. | | X | | |
| 3. Work with the Ohio Chapter of AAP to link to foster care notebook. | | | X | |
| 4. Finalize connection with ODH Bureau of Early Intervention Services medical home autism services. | | | | X |
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**b. Current Activities**
Performance Measure 03: The percent of children with special health care needs age 0-18 years who receive coordinated, ongoing, comprehensive care within a medical home. (CYSHCN survey)

Strategies for the Current FFY 10/1/2011 -- 9/30/2012:

Strategy A: Strengthen medical home, particularly in the area of coordination of services for families and providers. Provided input as one of Ohio's Sister Agencies during development of Ohio's Medicaid Health Homes for individuals with Serious and Persistent Mental illness.

Strategy B: Continue to support Cincinnati Children's Hospital Special Needs Resource Directory.

Strategy C: Work with the Ohio Chapter of AAP to link to foster care notebook.

Strategy D: Finalize connection with ODH Bureau of Early Intervention Services medical home autism services.

**c. Plan for the Coming Year**
Performance Measure 03: The percent of children with special health care needs age 0-18 years who receive coordinated, ongoing, comprehensive care within a medical home. (CYSHCN survey)

1. Increase demand for quality pediatric medical home services by improving knowledge and understanding of medical home among families and professionals.
Our program is the Title V partner on the "Ohio Statewide Medical Home Project for CYSHCN", the HRSA State Implementation Grant for CYSHCN. This project is supporting ongoing medical home trainings, including the training of public health nurses, Family to Family Health Information Specialists and new facilitators, who will then reach additional target local audiences. In addition to improving how these professionals partner with families in decision making, this strategy will improve knowledge about medical home definition, selection, access utilization and advantages with the goal of increased demand for quality pediatric medical home services in Ohio. Over the next two years, we will also partner on the development and distribution of medical home materials, including a care notebook, by refining and revising existing medical home materials and content.
We are also partnering with "REAL Action in Ohio: Resources, Education, Alignment and Linkages", the HRSA State Implementation Grant for Autism and Related Developmental Disabilities which was awarded to the Ohio Department of Developmental Disabilities. This grant is also planning development and dissemination of materials for families about medical home. We will facilitate collaboration between these two projects to ensure a unified message for our Ohio families.

2. Strengthen medical home, particularly in the area of coordination of services for families and providers
We will continue to work collaboratively with medical home initiatives in our state including Ohio's Patient Centered Medical Home Education Pilot Project which selected 44 practices in the state to undergo transformation to Patient Centered Medical Homes. Additionally, our program will continue to facilitate pediatric involvement in the Ohio Patient-Centered Primary Care Collaborative (PCPCC). This collaborative is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals working together to support and promote the Patient-Centered Medical Home model of healthcare delivery in Ohio. Representatives from our Title V CYSHCN program served on committees during development of Ohio Medicaid's Community Behavioral Health Center Health Home plan which will serve Ohioans with serious and persistent mental illness including children with serious emotional disturbance. Likewise, we plan to provide representation on committees when Ohio Medicaid begins work on the Primary Care Health Home plan.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |
| Annual Indicator | 64.6 | 64.6 | 64.6 | 64.6 | 64.8 |

| | | | | | |
|---|---|---|---|---|---|
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
The percent of Ohio children with special health care needs age 0 to 18 whose families had adequate private and/or public insurance to pay for the services they needed was 64.8% (95% C.I., 60.3%-69.3%) , slightly higher than the national percentage of 60.6% (95% C.I., 59.7%-61.4%; National Survey of Children with Special Health Care Needs, 2012). In general, Ohio's stratum-specific percentages were marginally higher than the national average, but confidence intervals overlapped (National Survey of Children with Special Health Care Needs, 2012). Stratum-specific proportions were higher for Ohio than the national proportions and both sets of 95% C.I. did not overlap among the 6 through 11 year-old age group (Ohio proportion 69.6%, 95% C.I., 62.7%-76.4%; national proportion 60.3%, 58.9%-61.8%), the specific type of special health need of prescription medicine and service use (Ohio proportion 71.8%, 95% C.I., 64.3%-79.3%; national proportion 61.4%, 59.6%-63.3%), one or more emotional, behavioral or developmental issues (Ohio proportion 64.7%, 95% C.I., 56.5%-73.0%; national proportion 53.6%, 52.0%-55.3%), children with four or more (of 14 named) functional difficulties (Ohio proportion 62.5%, 95% C.I., 55.6%-69.3%; national proportion: 52.6%, C.I., 51.2%-54.0%), a household income of 100%-199% of the federal poverty level (Ohio proportion 75.5%, 95% C.I., 68.4%-82.6%; national proportion: 58.0%, C.I., 55.9%-60.1%), and having public insurance (Ohio proportion 74.1%, 95% C.I., 66.7%-81.5%; national proportion 63.3%, 61.6%-64.9%). When the State of Ohio was lower than the national average, the 95% confidence overlapped or the cell size was less than 50, thus having too few respondents for an acceptable level for comparison.

Criteria for meeting the National Performance Measurement #4 has not changed since the original survey in 2001, so comparisons can be made between all three surveys. In the two previous surveys, Ohio's proportion on this measure was higher than the national average, but there was overlap in the 95% confidence intervals, like in the current survey. Strata response changes over the survey iterations limit the number of comparisons. Analysis for additional

statistical significance and trending may occur in the future.
Reference:

National Survey of Children with Special Health Care Needs. NS-CSHCN 2001. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 05/02/2012 from www.childhealthdata.org.
National Survey of Children with Special Health Care Needs. NS-CSHCN 2005/06. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 05/02/2012 from www.childhealthdata.org.

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**a. Last Year's Accomplishments**
Performance Measure 04: The percent of children with special health care needs age 0-18 years whose families have adequate private and/or public insurance to pay for the services they need. (CYSHCN survey)

1. Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN.
During the application process for the BCMH program, BCMH staff routinely inform families of programs for which their child may be eligible including Medicaid/SCHIP. Once enrolled in the BCMH program, BCMH staff help families coordinate insurance benefits with BCMH benefits/providers. Staff also advise parents on how to follow up when appealing insurance denials of services believed to be inappropriately denied. BCMH, through ODH, works actively with the Governor's Office of Health Transformation (OHT) team. OHT is charged with improving access to services and coordination of services in a centralized manner across all state agencies and programs.

2. Work with stakeholders in expansions of Medicaid for Children/SCHIP and Children's Buy-In Program.
These programs were not expanded in Ohio due to budget constraints. BCMH continues to work closely with Medicaid to identify gaps in medical services for CYSHCN.

3. Train local health departments, hospital based service coordinators on state and federal changes.
BCMH trained local health departments, public health nurses, and hospital based service coordinators on state and federal changes during quarterly regional meetings with local public health nurses and hospital based service coordinators.

4. Maintain CYSHCN data capacity, include questions in the Ohio Family Health Survey relative to CYSHCN.
The Ohio Department of Health continues to sponsor the Ohio Family Health Survey in partnership with other state agencies. The Ohio DD Council used these survey results to support research assessing the effects of caring for children with disabilities on families in Ohio. BCMH and EI staff worked with the DD Council team to develop, "Caring for Children with Disabilities in Ohio: The Impact on Families" which was released in Spring 2011. This report, which examines income, financial stress, employment, and emotional impact on families caring for children with disabilities, is being used by state agencies, legislators and families to show the economic and societal impact of caring for a child with disability in Ohio.

5. Provide educational material regarding impact of federal health care reform for CYSHCN on web-site.
The ODH website is currently upgrading its platform. After the upgrade is complete, BCMH is

planning to add these informational materials related to federal health care reform consistent with guidance from ODH administration.  The ODH website has provided information to Ohioans related to health care reform.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN. | | X | | |
| 2. Work with stakeholders in expansions of Medicaid for Children/SCHIP and Children's Buy-In Program. | | | | X |
| 3. Train local health departments, hospital based service coordinators on state and federal changes. | | X | | |
| 4. Maintain CYSHCN data capacity, include questions in the Ohio Family Health Survey relative to CYSHCN. | | | | X |
| 5. Provide educational material regarding impact of federal health care reform for CYSHCN on web-site. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Performance Measure 04:  The percent of children with special health care needs age 0-18 years whose families have adequate private and/or public insurance to pay for the services they need. (CYSHCN survey)

Strategies for the Current FFY 10/1/2011 -- 9/30/2012:

Strategy A: Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN.

Strategy B: Train local health departments, hospital based service coordinators on state and federal changes.

Strategy C: Maintain CYSHCN data capacity, include questions in the Ohio Family Health Survey relative to
CYSHCN.

Strategy D: Provide educational material regarding impact of federal health care reform for CYSHCN on web-site. BCMH will continue to add informational information and materials related to federal health care reform consistent with guidance from ODH administration.

**c. Plan for the Coming Year**

Performance Measure 04:  The percent of children with special health care needs age 0-18 years whose families have adequate private and/or public insurance to pay for the services they need. (CYSHCN survey)

1. Promote awareness of public and private sources of financing of needed health care services

to providers, stakeholders and families of CSHCN.
During the application process for the BCMH program, BCMH staff routinely informs families of programs for which their child may be eligible including Medicaid/SCHIP. Once enrolled in the BCMH program, BCMH staff helps families coordinate insurance benefits with BCMH benefits/providers. Staff also advises parents on how to follow up when appealing insurance denials of services believed to be inappropriately denied. BCMH, through ODH, works actively with the Governor's Office of Health Transformation (OHT) team. OHT is charged with improving access to services and coordination of services in a centralized manner across all state agencies and programs. We will continue active involvement in a committee examining eligibility across health and human services programs. We are also engaged directly with Ohio Medicaid to look for potential duplication or gaps in services. Our Medicaid liaison and parent consultant are engaging with managed care plan advisory groups related to the planned move of the ABD population into Medicaid managed care and for discussion of potential gaps in services for CYSHCN.

2. Provide information to our key partners and stakeholders related to economic impact of caring for a child with disability in Ohio.
The Ohio Department of Health continues to sponsor the Ohio Family Health Survey (Ohio Medicaid Assessment Survey) in partnership with other state agencies. The Ohio DD Council used these survey results to support research assessing the effects of caring for children with disabilities on families in Ohio. BCMH and EI staff worked with the DD Council team to develop, "Caring for Children with Disabilities in Ohio: The Impact on Families" which was released in spring 2011. This report, which examines income, financial stress, employment, and emotional impact on families caring for children with disabilities, is being used by state agencies, legislators and families to show the economic and societal impact of caring for a child with disability in Ohio. Our program is using this Ohio specific data when presenting to partners around our state related to Ohio's CYSHCN.

3. Provide educational material regarding impact of federal health care reform for CYSHCN on web-site.
The ODH website has completed upgrade and our program plans to add informational materials related to federal health care reform consistent with guidance from ODH administration. The ODH website has provided information to Ohioans related to health care reform.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 95 | 95 | 95 | 95 |
| Annual Indicator | 92.2 | 92.2 | 92.2 | 92.2 | 65.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 95 | 95 | 95 | 95 | 95 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
The percent of Ohio children with special health care needs age 0 to 18 whose families reported the community-based service systems are organized so they can use them easily was nearly equal to that for the nation, 65.2% (95% C.I., 60.8%-69.7%) and 65.1% (95% C.I., 64.2%-66.0%), for Ohio and the U.S., respectively (National Survey of Children with Special Health Care Needs, 2012).

This measure could not be compared with previous versions of the NS-CSHCN as the measurement changed significantly in the recent survey. In general, Ohio's percentages within various strata were equal to the national percentages. When the State of Ohio was higher or lower than the national average, the 95% confidence overlapped or the cell size was less than 50, thus having too few respondents for an acceptable level for comparison. Review of the subcomponents did not show any single question that had drastic differences from the national proportions and confidence intervals. Statistical testing to acquire additional information may occur in the future.

Reference:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 05/02/2012 from www.childhealthdata.org.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**a. Last Year's Accomplishments**

1. Promote organization of community-based services so that CSHCN families report they can use them easily.
Staff from BCMH and EI worked as members of the Early Childhood and Child Health Care Coordination Team which was convened by the Ohio Office of Health Transformation. The group developed a statement of strategic direction regarding the future of care coordination, developed desired attributes of a system and will be designing and implementing an early childhood care coordination pilot project.

2. Work with Ohio Family Voices & other parent groups to address community-based weaknesses.
Work has continued with Family Voices of Ohio and the Family to Family Health Information Specialists. These family leaders serve as ad hoc members of the BCMH Parent Advisory Council and attend local public health nurse trainings which support communication about community-based service systems and related needs of CYSHCN and their families.

3. Promote usage of Benefit Banks to assist families in filling out CPA and other assistance materials.
Usage of the Combined Program Application through the Benefit Bank was promoted by the BCMH Customer Service Unit at local Help Me Grow and BCMH trainings. Public health nurses, Family Voices and the Family Information Specialists have been oriented to this service.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Promote organization of community-based services so that CSHCN families report they can use them easily. | | | | X |
| 2. Work with Ohio Family Voices & other parent groups to address community-based weaknesses. | | X | | |
| 3. Promote usage of Benefit Banks to assist families in filling out CPA and other assistance materials. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Strategies for the Current FFY 10/1/2011 -- 9/30/2012:

Strategy A: Promote organization of community-based services so that CSHCN families report they can use them easily.

Strategy B: Work with Ohio Family Voices & other parent groups to address community-based weaknesses.

Strategy C: Promote usage of Benefit Banks to assist families in filling out CPA and other assistance materials.

**c. Plan for the Coming Year**

1. Promote organization of community-based services so that CSHCN families report they can use them easily.
BCMHEIS worked with the Early Childhood and Child Health Care Coordination Team convened by the Ohio Office of Health Transformation to develop a statement of strategic direction regarding care coordination and desired attributes of a system. BCMHEIS will be active in the development, implementation and evaluation of an early childhood care coordination pilot project using the HUB/Pathways model of care coordination which has implication for a statewide care coordination model.

The Metabolic Formula program is working with leadership from Ohio Medicaid and Ohio WIC during the Medicaid enteral rules revision process to improve ease of acquisition of medically necessary formulas for Ohio children and families with special nutritional needs such as tube feeding, metabolic disorders, severe food allergy or Cystic Fibrosis.

2. Promote and support usage of coordinated statewide web based information and application systems.
Work with the Ohio Benefit Bank to ensure programs are accurately represented to families by identifying and linking children with the appropriate application process to determine eligibility. Usage of the Combined Program Application through the Benefit Bank has been promoted to public health nurses, Family Voices and Family Information Specialists. We will continue to work to ensure awareness of this resource and that the resource functions to meet the needs of our families.

Maintain and improve BCMHEIS websites to include up-to-date information with input from parent and provider groups. Continue to work with RedTreehouse.org, online resources for Ohio's families and professionals to help children and young adults meet daily needs, overcome challenges, and develop their fullest potential. This resource will link families to local resources including parent trainings and support group meetings.

3. Partner in development of innovative strategies to enhance ease of use of systems in Ohio.
BCMHEIS is working with the "Ohio Statewide System of Services for early Intervention: Bridging the Gaps in Ohio Part C Service Delivery" project sponsored by Ohio's DD Council and led by the Ohio Association of Services for Children and Ohio Association of County Boards of Developmental Disability. The project will use telehealth technology to engage families, Help Me Grow service providers and primary care providers in early intervention services promoting improved coordination of systems and the medical home model.

The Building Mental Wellness (BMW) Learning Collaborative, supported by Ohio Colleges of Medicine Government Resource Center and funded by ODH and ODJFS, is being led by the Ohio Chapter of the American Academy of Pediatrics. BMW is designed to improve the delivery of children's mental health services, including anticipatory guidance, screening, early diagnosis and management of social-emotional problems in primary care.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 25 | 50 | 50 | 50 | 50 |
| Annual Indicator | 48.5 | 48.5 | 48.5 | 48.5 | 35.6 |
| Numerator | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | | | | | |
| Data Source | | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 50 | 50 | 50 | 50 | 50 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
The percentage of Ohio youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence was slightly lower than that of the nation, with a proportion of 35.6% (95% C.I., 29.2%-42.0%) in Ohio, compared to the national proportion of 40.0% (95% C.I., 38.7%-41.4%; National Survey of Children with Special Health Care Needs, 2012).

Stratum-specific proportions were lower for Ohio than the national proportions and both sets of 95% C.I. did not overlap among the race and ethnicity group of white and non-Hispanic (Ohio proportion 36.4%, 95% C.I., 29.1%-43.6%; national proportion 45.7%, 44.1%-47.2%). Otherwise, Ohio's percentages were slightly lower than the national proportions within many strata identified by the Data Resource Center for Child and Adolescent Health. When the State of Ohio was higher or lower than the national average, the 95% confidence overlapped or the cell size was less than 50, thus having too few respondents for an acceptable level for comparison.

Comparison to the previous survey (2005/06) was available for this measure. In the previous survey, Ohio's percentage was higher (48.5%, 95% C.I., 42.0%-54.9%) than the national percentage (41.2%, 95% C.I., 39.9%-42.5%) although the 95% confidence intervals overlapped. Overall, from the previous survey to current, Ohio's performance on this measure has decreased. It was noted that Ohio's subcomponent measure, "Discussed changing health needs as youth becomes an adult", had a substantial decrease of affirmation compared to the previous survey. Only two other states exceeded Ohio's proportional increase for the response, "No, did not discuss this and would have been helpful". Similarly, Ohio's proportion change for the response, “Did not get all needed anticipatory guidance” for the subcomponent, “Anticipatory guidance for transition to adult health care” was an even greater increase for Ohio, with only one state having a larger proportion change. We are not sure why such shifts in these proportions were seen but intend to complete further analysis of the survey to inform programs and begin statewide change.

Reference:
National Survey of Children with Special Health Care Needs. NS-CSHCN 2005/06. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 05/02/2012 from www.childhealthdata.org.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2009**
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**a. Last Year's Accomplishments**
Performance Measure 06: The percent of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

1. Maintain a forum for youth with special health care needs and receive information on services and supports.
BCMH staff actively participates in initiatives of the Ohio Family and Children First Council which includes youth engagement. Activities of this multi agency group include:
•Family Engagement and Empowerment in Ohio
•Service Coordination Guide for Families
•Transition for Youth

2. Conduct quarterly regional meetings with Young Adult Advisory Council (YAAC). Expand regions of the YAAC
The retirement of the previous Bureau Chief/Medical Director and Parent Consultant from ODH/BCMH has delayed this work. The new Bureau Chief/Medical Director and Parent Consultant are now in place and will begin work to revitalize the youth advisory component of the program.

3. Recruit physician providers for youth transitioning to adult care.
The need for physician providers for youth with special health care needs transitioning to adult care continues to be discussed with providers on the combined BCMH and AAP Children with Disabilities Committee. The issue of transition in medical services for youth with special health care needs will receive additional focus in the future.

4. Provide trainings to youth regarding impact of federal health care reform.
BCMH has informed parents, advocates and public health nurses about the insurance option which allows youth to be maintained on their parents insurance until 28 years of age through trainings and mailings.

5. Educate policy makers on insurance coverage needs for young adults with medical needs. BCMH staff help represent ODH as one of the Sister Agencies providing input to Ohio Department of Jobs and Family Services/Ohio Medicaid regarding the special needs, characteristics, service needs and care coordination strategies for CYSHCN transitioning from Medicaid fee-for-service to the Medicaid managed care delivery system.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Maintain a forum for youth with special health care needs and receive information on services and supports. | | X | | |
| 2. Conduct quarterly regional meetings with Young Adult Advisory Council (YAAC). Expand regions of the YAAC | | X | | |
| 3. Recruit physician providers for youth transitioning to adult care. | | X | | |
| 4. Provide trainings to youth regarding impact of federal health care reform. | | X | | |
| 5. Educate policy makers on insurance coverage needs for young adults with medical needs. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Strategies for the Current FFY 10/1/2011 -- 9/30/2012:

Strategy A: Maintain a forum for youth with special health care needs and receive information on services and supports.

Strategy B: Conduct quarterly regional meetings with Young Adult Advisory Council (YAAC). Expand regions of the YAAC

Strategy C: Recruit physician providers for youth transitioning to adult care.

Strategy D: Provide trainings to youth regarding impact of federal health care reform.

Strategy E: Educate policy makers on insurance coverage needs for young adults with medical needs.

**c. Plan for the Coming Year**
MCH National Performance Measure 06: The percent of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

1. Convene a workgroup/sub-committee to address the significant gap in access to transition to adult health care for CYSHCN in Ohio.

Children with Medical Handicaps leadership will begin collaboration with members of the Ohio AAP Chapter, Children with Disabilities Committee to discuss potential strategies to address the identified need to train health care providers to address changing health needs as youth become adults and to address anticipatory guidance for transition to adult health care. Existing materials and resources including the clinical report, "Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home," from the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and American College of Physicians (ACP), published in July 2011 and the National Center for Medical Home Implementation will be used. We will also plan to leverage our relationship with adult primary care providers through Ohio's Patient Centered Medical Home Education Pilot Project and the Ohio Patient-Centered Primary Care Collaborative (PCPCC) to begin to build partnerships between the adult and pediatric care communities to address transition.

2. Revitalize youth advisory component of the Children with Medical Handicaps program.
The new Bureau Chief/Medical Director and Parent Consultant are now in place and will begin work to revitalize the youth advisory component of this program. BCMH staff actively participates in initiatives of the Ohio Family and Children First Council which includes youth engagement. Activities of this multi-agency group include: Family Engagement and Empowerment in Ohio, Service Coordination Guide for Families and Transition for Youth.

3. Educate policy makers on insurance coverage needs for young adults with medical needs.
Children with Medical Handicaps staff continue to represent ODH as one of the Sister Agencies providing input to Ohio Department of Jobs and Family Services/Ohio Medicaid regarding the special needs, characteristics, service needs and care coordination strategies for CYSHCN transitioning from Medicaid fee-for-service to the Medicaid managed care delivery system.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 85 | 85.5 | 86 | 86 | 82 |
| Annual Indicator | 80.4 | 80.4 | 73.8 | 76.0 | 76.0 |
| Numerator | 172568 | 172568 | 158300 | 163124 | 163124 |
| Denominator | 214637 | 214637 | 214637 | 214637 | 214637 |
| Data Source | | National Immunization Survey | National Immunization Survey | National Immunization | National Immunization |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |

| Is the Data Provisional or Final? | | | | Final | Provisional |
|---|---|---|---|---|---|
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 82.5 | 83 | 83.5 | 84 | 84 |

**Notes - 2011**
2011 data is provisional based on final 2010 data. In Ohio in 2010, 76 percent of all children aged 19 through 35 months received all recommended vaccines. This is significantly higher than in the previous year (73.8). Nationally the immunization rate is 72 percent. This rate includes the number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday. Complete immunization status is generally considered to be: 3 Hepatitis B ; 4 DtaP ; 3 Polio ; 1 MMR ; and 3 Hib. Ohio is better than the national average for most of these individual vaccine rates, but Ohio does fare worse than the average state on several vaccines not included in this data such as varicella, Hep A and Rotavirus.

**Notes - 2010**
ODH would like to inquire if there is any way the CDC would consider including "Varicella" in the vaccine series?

**Notes - 2009**
The 2009 data is currently not available we have used the 2008 data as an estimate for 2009.

**a. Last Year's Accomplishments**
Overall, Ohio's 4:3:1:3:3:1 coverage rate was 76%.

A. Monitor immunization data from DCFHS funded programs.

Accomplishments: WIC completed a statewide rollout of the required use of the Ohio IMACT immunization tracking system in 2011. Beginning October 1st 2011, the immunization section of the WIC data collection system was removed therefore the only option WIC clinics have to fulfill the federal requirements for immunizations is to use statewide IMPACT immunization registry system. The WIC policy and procedure manual has been updated to reflect the required use of the IMPACT system and staff have been trained. WIC is working closely with the IMPACT team to help resolve any issues WIC clinics may have in adopting the new system. The Child and Family Health Services program showed 68 percent of CFHS children were fully immunized or in progress -- an increase from 66 percent the previous year.

B. Promote the use of the statewide immunization registry by DFCHS funded programs

Accomplishments: CFHS subgrantees were monitored by assigned program consultants using the program specific data collection systems. BCHSSD promoted immunizations and the statewide immunization registry within schools that have school-based clinics.

C. Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs

Accomplishments: Of the 70 subgrantees funded by the CFHS Grant, 25 provide child and adolescent direct health care. Standards for this program require immunizations to be provided and tracked. Children who are enrolled in the Help Me Grow program have their immunization needs addressed in the Individual Family Service Plan. Educational pamphlets on immunizations are dispersed to families during Health Fairs and concentrated campaigns utilizing community health assessment data to determine areas of need. Health Professionals within the local WIC clinics review both the immunization records of the children being certified/recertified and the schedule of immunizations with parents and guardians. The Immunization Program collaborated with Early Intervention Program to provide an immunization information update webinar to Help Me Grow field consultants that is archived on-line.

D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

Accomplishments: This infrastructure-level strategy will be accomplished by working with SPM 4 Workgroup. See SPM 4 accomplishments.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Monitor immunization data from DCFHS funded programs. | | | | X |
| 2. Promote the use of the statewide immunization registry by DFCHS funded programs | | | | X |
| 3. Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs | | | | X |
| 4. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
National Performance Measure 07: The percent of 19-35 month olds who have received full schedule of immunizations

Strategies for the Current FFY 10/1/2011 -- 9/30/2012:

Strategy A: Monitor immunization data from DCFHS funded programs.

Strategy B: Promote the use of the statewide immunization registry by DFCHS funded programs.

Strategy C: Collaborate and coordinate immunization planning and programming efforts with national,
state and local health programs .

Strategy D: Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

**c. Plan for the Coming Year**
National Performance Measure 07: The percent of 19-35 month olds who have received full schedule of immunizations

A. Monitor immunization data from DCFHS funded programs.

This infrastructure-level strategy will be accomplished by analyzing data from the following sources: CFHS program (MATCH) and WIC program.

B. Promote the use of the statewide immunization registry by DFCHS funded programs

This infrastructure-level strategy will be accomplished by 1) monitoring those CFHS subgrantees providing child health services; 2) working through the ODH School Nurse p
rogram to promote an awareness campaign within schools that have school-based clinics; and 3) working with the Rural Health program to promote provider awareness at the annual Rural Health Conference.

C. Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs

This infrastructure-level strategy will be accomplished by collaborating with Ohio Health Plans (Medicaid) and other stakeholder groups; and by working with local WIC projects to ensure that children are referred for immunization services.

D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 18 | 18 | 18 | 18 | 17.7 |
| Annual Indicator | 19.7 | 19.7 | 18.7 | 15.6 | 15.6 |
| Numerator | 4798 | 4717 | 4391 | 3699 | 3699 |
| Denominator | 243435 | 239491 | 235168 | 236407 | 236407 |
| Data Source | | Ohio Vital Statistics and US Census | Ohio Vital Statistics | Ohio Vital Statistics | Ohio Vital Statistics 2011 US Census 2010 Estimate |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 17.6 | 17.5 | 17.4 | 17.3 | 17.3 |

**Notes - 2011**
Provisional 2011 Data entered for FFY2013 was based on Final 2010 Data.

**Notes - 2009**
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

**a. Last Year's Accomplishments**
Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

This performance measure has not been met although progress is being made. Data for 2010 is unavailable; 2009 data reports the rate of birth for teenagers aged 15 to 17 years is 18.7 compared to the 2008 rate of 19.7. The goal is a rate of 18.

A. Evaluate the Reproductive Health & Wellness Programs (RHWP) to determine if they are utilizing evidence-based practices to reduce factors contributing to teen pregnancy. (infrastructure)

In the competitive Request for Proposals, the RHWP program gave the opportunity for sub-grantees to apply for enhanced funds to provide evidence based comprehensive reproductive health and wellness education to reproductive aged males and females. Eight out of 36 agencies chose to provide this.

ODH was awarded the Personal Responsibility Education Program (PREP) grant and two RHWP agencies were awarded monies to implement the curriculum, adapted Reducing the Risk including adulthood transition topics in their regions of the state. These funds will provide for training of frontline staff in the foster care and juvenile justice settings so those staff can use the curriculum with these high risk youth.

B. Require outreach activities in RHWP to have evidence-based programs which require applicants to utilize at least one in the program plan for Year One of the project cycle (infrastructure). The programs are to show pre-post test changes in learning, knowledge, and attitudes of participants. (infrastructure)

All RHWP agencies were required to provide outreach activities with 5% of their grant award in the 2012 Request for Proposals (RFP). Training on conducting outreach was presented at a RHWP project director's meeting in September.

Teens comprised nearly 25% (11,642) of patients seen during this year and 26% (20,554) of all visits.

RHWP participates as a member of the Ohio Adolescent Health Partnership. The group addresses five issues important to the health & wellness for adolescents: REPRODUCTIVE HEALTH, MENTAL HEALTH, INJURY/VIOLENCE, SUBSTANCE ABUSE, & SLEEP/NUTRITION. It is hoped that concentrating on these issues will give teens the tools they need to make a healthy decision about their sexual health, which should have a direct impact on teen pregnancy.

C. Train all RHWP nurses to provide interventions to teens reporting sexual coercion (infrastructure). This will be done collaboratively as "Project Connect" between Ohio Domestic Violence Network and the RHWP staff. There will also be inter-agency collaboration between the RHWP sub-grantees and community domestic violence resources. The outcome will be seen in the number of clients reporting sexual coercion, the number referred for services, and the total number served. (infrastructure)

With collaboration with the Ohio Domestic Violence Network's (ODVN), the RHWP established guidelines and provided training to staff in addressing violence and reproductive coercion in family planning and adolescent health programs. Project Connect is a violence prevention initiative awarded to ODVN through the U.S. Department of Health & Human Services. RHWP has worked diligently with Project Connect to train staff in the screening, referral and reporting of sexual coercion in adolescents. A need was discovered to provide more education on adolescent sexual coercion and birth control sabotage, as well as mandated reporting.

Webinar education programs on mandated reporting were provided to all RHWP sub-grantees in July. Education has been provided by consultants to program directors and staff on sexual coercion and data entry to monitor results, as well as assistance in developing relationships with local shelters, children's agencies and local law enforcement.

RHWP Consultants attended the Project Connect Family Planning and Adolescent Health Training of Trainers in October, 2011. Training was provided on how to identify sexual violence/coercion in the teen population, the impact of violence on reproductive and teen health, unique considerations for teens: developmental and integrated frameworks, and foundations for teaching the dynamics of sexual violence to teen health and family planning providers. Trainings have been scheduled for RHWP clinics throughout the state of Ohio in 2012.

This year, 359 patients reported sexual coercion while only 31 patients were referred for sexual coercion. RHWP served 47,792 patients in this time period.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Evaluate the Reproductive Health & Wellness Programs (RHWP) to determine if they are utilizing evidence-based practices to reduce factors contributing to teen pregnancy. | | | | X |
| 2. Require outreach activities in RHWP to have evidence-based programs which require applicants to utilize at least one in the program plan for Year One of the project cycle | | | | X |
| 3. Train all RHWP nurses to provide interventions to teens reporting sexual coercion | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

A. This strategy has been revised. The new strategy is to collaborate with the Adolescent Health program which is proviing grant opportunities throughout the state to support evidenced based curriculums to reduce teen pregnancy.

B. This strategy has been deleted. No evidenced-based programs currently exist for outreach activities in Reproductive Health and Wellness.

C. The workgroup is actively working on this strategy.

**c. Plan for the Coming Year**
Plan for the Coming Year
A. Ensure that all Reproductive Health and Wellness Program (RHWP) patients complete a Reproductive Life Plan.

B. Increase the number of patients aged 15 through 17 years in RHWP.

C. Provide evidence based comprehensive reproductive health and wellness education to persons under age 18 through RHWP.

D. Train frontline staff in foster care and juvenile justice settings in Reducing the Risk through the Personal Responsibility and Education Program.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 47 | 48 | 51 | 51 | 51 |
| Annual Indicator | 42.2 | 50.9 | 50.4 | 50.4 | 50.4 |
| Numerator | 53703 | 64341 | 66157 | 66157 | 66157 |
| Denominator | 127146 | 126407 | 131392 | 131392 | 131392 |
| Data Source | | Annual School Survey | Annual School Survey | Annual School Survey | Annual School Survey |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 51 | 51 | 51 | 52 | 52 |

**Notes - 2011**
2011 provisional data is based on 2010 final data. Ohio uses a statewide open-mouth oral health survey (using the Basic Screening Survey model) to estimate this measure. About every five years (2009-10 was the most recent) the survey is completed at the county level. The next survey will be conducted from 2013-2015.

**Notes - 2010**
Provisional 2010 Data for FFY2012 based on Final 2009 Data.
From the 2009-2010 Oral Health Survey of 377 schools which provided a population-based estimate for the state. Numerator: Actual number of children in the sample who received protective sealants = 7533 (population estimate = 66,157). Denominator: Actual number of children in the sample who were screened = 14,959 (population estimate = 131,392).

Final 2010 Data: Ohio uses a statewide open-mouth oral health survey (using the Basic Screening Survey model) to estimate this measure. About every five years (2009-10 was the most recent) the survey is completed at the county level. The next survey will be conducted from 2013-2015.

**Notes - 2009**
Data Source: From the 2009-2010 Oral Health Survey of 377 schools which provided a population-based estimate for the state. Numerator: Actual number of children in the sample who received protective sealants = 7533 (population estimate = 66,157). Denominator: Actual number of children in the sample who were screened =
14,959 (population estimate = 131,392).

**a. Last Year's Accomplishments**
Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs.

This infrastructure-level strategy will be accomplished through the following activities:

1) Implement the plan for expanding the number of schools and children served by ODH-funded sealant programs.
ODH's dental sealant program serves high risk second and sixth graders in eligible schools. (40% or more of the children enrolled are eligible for the Free and Reduced Price Meal Program). ODH received funding from HRSA to increase the number of high-risk students receiving sealants through school-based sealant programs. This funding supported expansion of existing dental sealant subgrants, the start-up of two new subgrants, and expansion of a locally funded sealant program in 2011. Eighteen dental sealant programs were funded to provide dental sealants to high risk students in 48 of Ohio's 88 counties. Even with the addition of more than 200 eligible schools to the sealant program, there was a 5% net increase in eligible schools, due to increasing participation in the Free and Reduced Price Meal Program.
In accordance with ODH's plan for expanding dental sealant programs, a dental sealant stakeholders meeting was conducted. Contacts continue with these stakeholders, as they determine local schools' interest and identify local funding for a program. Follow-up meetings were held in two of the regions identified by ODH for potential development of local sealant programs in eligible schools.

The Ohio School-based Dental Sealant map and summary data were updated and are posted on the ODH Web site.

Data from the 2009-10 statewide survey of Ohio third graders show that Ohio attained the Healthy People 2010 National Objective for the percentage (50%) of children with one or more sealants.

2) Evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan based on implementation in 2010. The evaluation will be based on an analysis of quarterly report data, site visits and other documentation, and site visits.
Following an evaluation of program report data, site visits and other documentation, the School-based Dental Sealant Program Manual, required reading for sealant program personnel, was updated in August 2011. Changes in the ODH Performance Improvement Plan for the statewide sealant program were proposed and updates will be completed, pending approval.

Program reports were reviewed and technical assistance provided to programs where concerns were identified. Training and technical assistance continue to be provided for all programs on program operations, accuracy of program reports and utilization of ODH's electronic grant reporting system. Site visits were conducted with six programs; three were comprehensive program reviews. Site visits are prioritized based on reports, contacts with programs and other documentation.

3) Update, as appropriate, the on-line distance learning curriculum for school-based sealant program staff.
No changes were made in 2011 to the on-line distance learning curriculum for school-based sealant program staff.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Implement the plan for expanding the number of schools and children served by ODH-funded sealant programs. | | | | X |
| 2. Evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan based on implementation in 2010. The evaluation will be based on an analysis of quarterly report data, site visits and other documentation, and site visi | | | | X |
| 3. Update, as appropriate, the on-line distance learning curriculum for school-based sealant program staff. | | | | X |
| 4. | | | | |
| 5. | | | | |
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| 10. | | | | |

**b. Current Activities**
Strategies for the Current FFY 10/1/2011 -- 9/30/2012:

Strategy A: Implement the plan for expanding the number of schools and children served by ODH-funded sealant programs.

Strategy B: Evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan based on implementation in 2010. The evaluation will be based on an analysis of quarterly report data, site visits and other documentation, and site visits.

Strategy C: Update, as appropriate, the on-line distance learning curriculum for school-based sealant program staff.

**c. Plan for the Coming Year**
National Performance Measure 09
Percent of 3rd graders who have received protective sealants on at least 1 permanent molar tooth

Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs (S-BSPs).

This infrastructure-level strategy will be accomplished through the following activities:
1) Implement the plan for expanding the number of schools and children served by ODH-funded sealant programs.

Continue to promote expansion of existing programs, as budgets permit, through a continuation RFP based on ODH's updated expansion plan. It is anticipated that a total of 18 programs will continue to provide dental sealants to high-risk students in 48 Ohio counties. ODH anticipates that the number of students who will receive sealants in 2013 will continue to increase.

Continue to update the S-BSP expansion plan. Discuss potential to develop alternatives to ODH grant funding to expand access to S-BSPs.

Explore methodologies to evaluate leading factors contributing to decreasing levels of participation in S-BSPs and identify strategies to increase positive consent return.

Monitor subgrantees' program and expenditure reports.

Program quality assurance, based on the School-based Dental Sealant Program Manual and Program Improvement Plan, will continue through technical assistance and site reviews for sealant subgrant programs.

Obtain data and review eligibility of schools for the sealant program.

Develop a competitive RFP for CY2014 and post it on the ODH Web site.

Review and update information available on the ODH Web site regarding the dental sealant program and related sealant information, as appropriate.

Update the 2013 Ohio School-based Dental Sealant map, showing the locations of sealant programs and the counties they serve, and post it on the ODH Web site.

Provide information, consultation and technical assistance to customers (e.g., local health departments, school staff, consumers), as needed.

2) Evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan. The evaluation will be based on an analysis of program report data, site visits and other documentation.

Review and update the Ohio School-based Dental Sealant Program Manual, as appropriate. Accuracy and consistency of subgrantee reporting will continue to be emphasized. Review and update the Performance Improvement Plan, as appropriate.

3) Update, as appropriate, the on-line distance learning curriculum for school-based sealant program staff.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 2.4 | 2.5 | 1.5 | 1.5 | 1.4 |
| Annual Indicator | 1.6 | 1.9 | 1.9 | 1.9 | 1.9 |

| | | | | | |
|---|---|---|---|---|---|
| Numerator | 33 | 40 | 40 | 39 | 39 |
| Denominator | 2104949 | 2087807 | 2087807 | 2104402 | 2104402 |
| Data Source | | Ohio Vital Statistics and US Census | Ohio Vital Statistics | OH Vital Statistics and US Census | OHVital Statistics 2010 birth files |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 1.4 | 1.4 | 1.4 | 1.4 | 1.4 |

**Notes - 2011**
2011 Provisional data for 2011 reported from 2010 final mortality file.

**a. Last Year's Accomplishments**
A. Rate of deaths was analyzed using provisional VS data. Rate of 1.9 is approaching objective of 1.5. Contributing factors of motor vehicle crash (MVC) fatalities for children under 18 have been monitored & analyzed via child fatality review (CFR) data. CFR data for children 1-14 were analyzed. 361 deaths in 2009 to 1-14 year olds were reviewed; 36 were MVC deaths. This is 42% of all MVC deaths reviewed for ages 0-17 years, same percentage as last year. The 36 MVC deaths represent 10% of all 1-14-year-old deaths from all causes; & 24% of all non-natural deaths (150) to 1-14 year olds, both lower percentages than last year.

B. Analysis of 36 MVC deaths found 20 involved death of child passengers, 3 involved death of child drivers, & 12 were cyclists or pedestrians. Of the 15 MVC deaths to black children, 9 (60%) were 1-14, & more than half were pedestrians or bikers. Of 14 deaths to 1-14 year olds in vehicles where restraint use is required by law, 4 (29%) were properly restrained. ODPS data confirm observed restraint use highest in SW region & lowest in SE region of state. CFR Annual Report & data shared at division meetings & overlapping work groups; CFR trainings; Combined Public Health Conference; Ohio Public Health Epidemiology Conference; Ohio Injury Prevention Partnership & CFR Advisory Committee & subgroup meetings. Report announced through media releases to newspapers, television & radio stations; & posted on ODH Website. Copies distributed throughout ODH & to elected officials, local CFR boards, Family & Children First Councils, & State Library system.

C. CFR boards encouraged to seek collaboration from community agencies to develop activities & initiatives in response to CFR findings. Technical assistance provided to CFR boards regarding effective ways to solicit & communicate with partners. Local boards partnered with schools & service organizations to provide bike & pedestrian safety events, free bike helmets & seat belt use incentives. Cooperation with law enforcement & traffic engineers resulted in roadway improvements, media messages re: driveway safety & targeted passenger restraint education. CFR boards active in broadcasting changes in Ohio's booster seat law and advocating strict enforcement. CFHS projects encouraged to include local CFR findings in community assessments & program planning.

D. ODH Injury Prevention (IP) program works closely with ODPS/Ohio Traffic Safety Office (ODPS/OTSO) to address child passenger safety (CPS) issues. With car seat fine dollars, ODH purchases safety seats that are distributed through a network (Ohio Buckles Buckeyes- OBB) of CPS programs. Each county has a designated agency to provide education & distribute CPS seats at no cost to financially eligible families. Grant from ODPS/OTSO supports these activities. Through grant, ODH has assumed responsibility for Occupant Protection Regional Coordinator (OPRC) Program, a network of nine regional CPS instructors & coordinators who provide training & technical assistance to local OBB sites. OPRCs plan & coordinate other occupant protection activities including CPS check-up events & fitting stations. Grant funds are used to purchase & print CPS educational materials, including materials to promote Ohio's new booster seat law, effective 10/7/2009. Website is maintained with booster seat-related information & resources. Memorandum of Understanding allows ODPS to share with ODH raw data from Trauma & EMS Registries. IP coordinates multi-disciplinary, statewide injury prevention coalition (OIPP) with a child injury action subgroup (CIAG).

CIAG identified review & revision of Ohio's child restraint law as a priority. Objectives include review current state law to identify gaps; promote & support needed changes to law; introduce pilot training program with state Highway Patrol regarding enforcement of child restraint law; & educate law enforcement agencies to increase enforcement of current law. CDC funding will be used to hire a Motor Vehicle Child Injury Prevention Policy (MVP) coordinator to forge partnerships with children's hospitals. IP & MVP coordinator & the children's hospitals work with staff & local coalitions to promote child passenger restraints, teen driving & bicycle & wheeled sports helmet use with partners such as private business, insurance, media, & other decision makers.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. CFR data for children 1-14 were further analyzed. | | | | X |
| 2. Utilize CFR boards to seek collaboration from community agencies to develop activities & initiatives in response to CFR findings. | | | | X |
| 3. The ODH Injury Prevention (IP) program works closely with the ODPS/Ohio Traffic Safety Office (ODPS/OTSO) to address child passenger safety (CPS) issues | | | | X |
| 4. | | | | |
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**b. Current Activities**
The strategies for NPM #10 have not changed for the FFY 2012.

**c. Plan for the Coming Year**
A. Use Vital Statistics data to monitor rate of MV deaths to children 1-14 years old. Use Child Fatality Review (CFR) data to monitor percentage of MV deaths among all deaths reviewed. Use Ohio Department of Public Safety (ODPS) crash report data to monitor county of MV deaths. This infrastructure-level strategy will be accomplished through the following activities:

1. Be alert to possible data quality issues;
2. Access additional data sources that include injury data to provide a more comprehensive look at the impact of MV crashes for 1-14 year olds.

B. Analyze factors that contribute to MV deaths of children 1-14 years old using CFR data &crash report data from ODPS. Share information with ODH programs, other state agencies, local health departments, child health partners & policymakers/legislators. This infrastructure-level strategy will be accomplished through the following activities:
1. Use analysis to identify groups with increased risks across the age group;
2. Include injury data for more comprehensive perspective;
3. Continue MV focus section in CFR annual report;
4. Use strategy workgroup plus other external partners to review data & give input;
5. Use multiple venues to disperse findings, such as ODH Website, e-mails, local health department conference calls, conference exhibits & presentations.

C. Encourage local CFR Boards to share information & recommendations about prevention of MV deaths of children 1-14 years old with local partners who can reach families & children, such as local media, Help Me Grow, county Family & Children First, Ohio Buckles Buckeyes, service agencies such as Kiwanis Clubs, child care providers & legislators. This infrastructure-level strategy will be accomplished through the following activities:
1. Provide TA, training & tools to local CFR boards re: ways to present & share information to audiences, including use of CFR data for funding applications;
2. Encourage cultural & linguistic competency in development of activities to prevent deaths & injuries from MV crashes, especially for pedestrian safety in urban areas & for educating public about child booster seat law;
3. Prepare fact sheets from data for MV deaths to 1-14 year olds & risk factors unique to age group.

D. Collaborate with injury programs at ODH & other state agencies, to develop strategies to decrease MV injuries & deaths among children, including proper use of safety devices & increasing pedestrian safety. This infrastructure-level strategy will be accomplished through the following activities:
1. Educate partners regarding issues, priorities & need to collaborate for solutions;
2. Use CFR Advisory Committee, strategy workgroup & Ohio Injury Prevention Partnership recommendations to engage partners, leverage influence & coordinate efforts to identify & implement changes to policy, practice or legislation to reduce child MV deaths.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 34 | 34.5 | 35 | 35.5 | 38 |
| Annual Indicator | 31.5 | 31.4 | 37.5 | 39.0 | 39.0 |
| Numerator | 46700 | 46700 | 54213 | 54213 | 54213 |
| Denominator | 148255 | 148592 | 144569 | 139034 | 139034 |
| Data Source | | CDC National Immunization Survey | CDC National Immunization Survey | CDC National Immunization Survey | CDC National Immunization Survey |

| | | | | | |
|---|---|---|---|---|---|
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 38.5 | 39 | 39.5 | 40 | 40 |

**Notes - 2011**
Provisional 2011 data awaiting new CDC data for the numerator. As of March 2012, the most recent numerator data available are 2008 provisional National Immunization Survey. The most recent denominator data available are from the Ohio 2010 birth files. According to the vital statistics records, breastfeeding initiation in Ohio has slowly increased over the past 6 years. The rate in 2010 was 67% and the provisional 2011 rate was 69%. In 2008, the most recent years for which national comparisons are available, Ohio had the 42nd lowest breastfeeding initiation rate of the 50 states. Ohio has also made progress in the proportion of infants breastfed at 6 months, which has increased from 30% in 2001 to 40% in 2008.

**Notes - 2010**
Provisional 2010 Data for FFY2012 based on 2009 data. The numerator for 2010 data continues to be provisional awaiting new data from CDC. Denominator is final ODH data.

**a. Last Year's Accomplishments**
A. Support BF components among ODH child obesity plan.
BF objectives were included in the Preventing Infant Mortality in Ohio: Task Force Report. Within the Statewide Wellness and Obesity Prevention Program grants; BF was one strategy that could be selected for funding and one funded agency used the Ounce of Prevention is Worth a Pound (Ounce) program to train health professionals on obesity prevention. Title V Director participated in cross agency work group to develop a State of Ohio agency lactation room policy. The activities represent the MCH pyramid by CFHS clinics providing direct care services, enabling, and population and infrastructure services. Services provided are anthropometric measurements, counseling, assessment, education, referrals, medical testing and preventative services. State Agency Wellness Coordinators received training on the Business Case for Breastfeeding as well as the new nursing mother regulations in health care reform bill; survey were distributed and data collected to determine the number of policy changes made since training. The Northeast and East regions of Healthy Ohio Business Council and the Creating Healthy Communities hosted Breastfeeding trainings; completed and data to be analyzed. Local WIC hospitals and WIC staff developed a coordinated approach to breastfeeding support session; 59 hospitals and 86 WIC staff attended. WIC RFP issued to reach WIC Appalachian and AA women's barrier to breastfeeding; research completed and summary of finding shared with stakeholders. 7 WIC BF Clinical workshops on engorgement and breastfeeding late preterm

infants were held; 45 nurses, 12 peer helpers and 146 health professionals attended. The strategy was accomplished.

B. Increase breastfeeding among Ohio's African Americans.
The WIC billboards promoting BF were displayed in African American communities. Ohio WIC is expanding the Breastfeeding Peer Helper Program statewide and by January 2011 all projects should have peers on staff. Ohio WIC also created a part time (20hours/week) breastfeeding peer program coordinator position. Ohio WIC continues to provide good quality, portable, electric breast pumps to mothers and infants with breastfeeding difficulties or when returning to work or school. The activities are enabling, population, infrastructure and direct care services. The services provided are education and referrals. The strategy is an ongoing effort with African Americans population but expanding.

C. Promote and support breastfeeding throughout the state of Ohio.
WIC billboards were erected and other media campaigns were held across the State of Ohio to promote BF to targeted populations. Ohio WIC is expanding the Breastfeeding Peer Helper Program statewide by January 2011 all projects should have peers on staff; 99% of WIC projects have at least one peer on staff. Ohio WIC also created a part time (20hours/week) breastfeeding peer program coordinator position. Ohio WIC continues to provide good quality portable, electric breast pumps to mothers and infants with breastfeeding difficulties or when returning to work or school. State BF Coalition was supported thru membership and collaboration; one meeting was attended, updates provided to both the collation and ODH staff with successful collaboration. Medically fragile infants on the BCMH Treatment program were provided donor breast milk at a cost of $20,610; completed September 2011 and data obtained from BCMH billing records. The activities represent the MCH pyramid by CFHS clinics providing direct care services, enabling, and population and infrastructure services. Services provided are anthropometric measurements, counseling, assessment, education, referrals, medical testing and preventative services. The strategy is an ongoing effort with WIC but still expanding.

D. Evaluate breastfeeding initiatives in WIC.
State Epidemiologist is conducting multi-level analysis using PedNSS data to evaluate Breastfeeding Peer Helper program. Preliminary results were presented in a poster session at the International Lactation Consultant Association Conference, July 2010. The strategy is an ongoing effort but still expanding. The Ohio WIC Breastfeeding Coordinator presented the results of the 2009 peer program evaluation at the ILCA conference. The Infrastructure services by identifying improvement needs through an evaluation process.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Support BF components among ODH child obesity plan. | | | | X |
| 2. Increase breastfeeding among Ohio's African Americans. | | | | X |
| 3. Promote and support breastfeeding throughout the state of Ohio. | | | | X |
| 4. Evaluate breastfeeding initiatives in WIC. | | | | X |
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**b. Current Activities**

Below is the Current Activities Report for NPM 11:

We have not changed any strategies. We have not dropped any.

A. Support breastfeeding (BF) objectives of the Ohio Collaborative for Preventing Infant Mortality (OCPIM) (Infrastructure)
B. Promote and support BF throughout the State of Ohio (Population-Based)
C. Review BF data to identify target population and intervention for Ohio (e.g. AA, Appalachians, teens, etc.) (Infrastructure)

**c. Plan for the Coming Year**
Goal: A. Support breastfeeding (BF) objectives of the Ohio Collaborative for Preventing Infant Mortality (OCPIM) and Ohio Perinatal Quality Collaborative (Infrastructure)

1. Attend all OCPIM meetings and BF subcommittees meeting and provide epidemiology support for BF related Task Force objective. This objective will be measured through the documentation of meetings attended and BF work of subcommittee that ODH staff contributed to.

2. Start human milk in 80% of 22-29 week gestational age infants by 72 hours of life and achieve = 100 ml/kg/day of human milk by 21 days of life. This objective will be measured through OPQC reports.

Goal B: Promote and support BF throughout the State of Ohio (Population-Based)
1. Continue supporting the implementation of Business Case for BF. This objective will be measured through the number of new lactation support programs and policies.

2. Continue a BF worksite award in Ohio. This objective will be measured through the number of awards given.

3. Continue to train WIC staff and BF promotion and support. This objective will be measured through the number of training and the number of staff attendees.

4. Plan culturally appropriate BF intervention based on findings from 2011 research on WIC AA and Appalachian population. Regional IBCLC project in Appalachian Counties and continue BF Peer Helper in every county. This objective will be measured through the intervention development and implementation.

5. Continue to provide donor breast milk for medically fragile infants on the BCMH Treatment Program. This objective will be measured through data obtained from BCMH billing records.

6. Continue to support State BF Coalition through membership and collaboration. This objective will be measured through the documentation of meetings attended, ODH updates provided to OBA, OBA updates provided to ODH and collaborative activities.

7. Promote Text for Baby throughout Ohio. This objective will be measured through tracking Text for Baby enrollment.

Goal: C. Review BF data to identify target population and intervention for Ohio (e.g. AA, Appalachians, teens, etc.) (Infrastructure)

1. Compare BF rates in PRAMS and Vital Statistics and NIS in 2006-2011 as available. This

objective will be measured through reports generated and reports shared.

2. Identify Ohio population with lowest BF rates using PRAMS or Vital Statistics data. This objective will be measured through reports generated and reports shared.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 99 | 99 | 99 | 99 | 98 |
| Annual Indicator | 92.2 | 92.6 | 96.5 | 97.6 | 97.6 |
| Numerator | 139550 | 138325 | 140412 | 136416 | 136416 |
| Denominator | 151353 | 149357 | 145546 | 139841 | 139841 |
| Data Source | | Universal Newborn Hearing Screening Data and Vital | Universal Newborn Hearing Screening Data and Vita | Universal Newborn Hearing Screening Data and Vital | Universal Newborn Hearing Screening Data and Vital |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 98 | 98 | 98 | 99 | 99 |

**Notes - 2011**
Provisional 2011 data is based on final 2010 data. Most hospitals are doing an excellent job, with more than 97% of infants screened at birth and reported to ODH. It is estimated that about 1% of Ohio births occur in an out-of-hospital setting. The program continues to strive towards its goal of ensuring the 99% of all Ohio infants born in hospitals are screened.

**Notes - 2010**
Most hospitals are doing an excellent job, with more than 97% of infants screened at birth and reported to ODH. It is estimated that about 1% of Ohio births occur in an out-of-hospital setting. The program continues to strive towards its goal of ensuring the 99% of all Ohio infants born in hospitals are screened.

**Notes - 2009**
The 2009 data is currently not available, 2008 data was used as an estimate for 2009. The 2009 data will be finalized in the next BG application.

**a. Last Year's Accomplishments**
Accomplishments
The goals of the infant hearing program are to ensure universal newborn screening, diagnostic follow-up for infants not passing the newborn screening, and early intervention services for infants identified with hearing loss.

-In calendar year 2010, about 97% of all infants born in Ohio were screened. Approximately 49% of those infants that did not pass their newborn hearing screening went on to complete a comprehensive diagnostic evaluation by three months of age.

Activity: Monitor and provide technical assistance to birthing and children's hospitals to assure all infants receive hearing screenings and that referral rates meet standards.

-The Consultant Audiologists continued to monitor and provide oversight for about 130 Universal Newborn Hearing Screening (UNHS) programs at hospitals and birthing centers to ensure compliance with UNHS legislation. The Consultant Audiologists utilized the hospital reports in the Integrated Perinatal Health Information System (IPHIS; vital statistics birth records) to monitor referral rates and track infants with missed screenings. They provide technical assistance as needed due to staff turnover and to ensure basic standards were met. The importance of how results are conveyed to families has been emphasized to hospital staff this year along with the need for complete and accurate data collection, including alternate contact information. About 97% of the 139,886 infants born in Ohio were reported as screened in 2010.

Activity: Monitor diagnostic reports from Pediatric Audiologists conducting diagnostic evaluations on infants not passing their newborn hearing screenings in order to meet the goal of identifying permanent hearing loss by three months of age.

-In 2010, the 4,591 infants that did not pass the newborn hearing screening were referred for comprehensive diagnostic evaluations. The follow-up evaluation results are reported to ODH and reviewed by the Consultant Audiologists. The Diagnostic Evaluations are forwarded to the Regional Infant Hearing Programs (RIHPs) for documentation of completion, additional follow-up for unconfirmed results, or to initiate habilitative services for infants with a confirmed hearing loss. The Consultant Audiologists contact audiology providers to educate them on the importance of submitting the forms when they are not received.

Activity: Identify pediatric audiologists providing follow-up diagnostic evaluations and other services for non-pass UNHS infants.

-Approximately 100 self-identified pediatric audiologists throughout Ohio are included in the Audiology Directory provided to Hospital UNHS Coordinators annually. Audiologists are surveyed at least annually and the Pediatric Audiology Directory is also posted at http://www.ohiohelpmegrow.org/parents/infanthearing/infanthearing.aspx. Parents, professionals, and RIHP staffs can search the directory by geographic location to find a conveniently located provider.

Activity: The RIHPs track non pass referrals and provide early intervention services for infants identified with permanent childhood hearing loss.

-The number of newborns screened, identified as non-passes, and referred to the RIHPs for follow-up remained constant at 3% of total births. About 2% of the non-pass group were identified with a permanent hearing loss and were offered habilitative services by the RIHPs.

Activity: The Infant Hearing Program, with input from the Advisory Subcommittee and the Genetics Program, continues to participate in collaborative initiatives.

-The Infant Hearing Program continues to meet quarterly with the UNHS Advisory Subcommittee to obtain stakeholder input. The Subcommittee also assisted with development and implementation of National Initiative for Children's Health Quality (NICHQ) activities.

In collaboration with the Genetics Program staff, another NICHQ activity was initiated in August, 2011. Staff reviewed a sample of diagnostic reports to determine whether infants and children diagnosed with hearing loss received a referral from the pediatric audiologist for a genetics evaluation. Genetic referrals were initiated by physicians and future plans include additional outreach to audiology providers. A Genetics Counselor also regularly attends Help Me Grow trainings to provide an overview of and literature on genetics.

Annual Performance Objective -- Percent Screened

| 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|
| 93 | 94 | 97 | 97 | 97 |

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Monitor and provide technical assistance to birthing and children's hospitals to assure all infants receive hearing screenings and that referral rates meet standards. | | | | X |
| 2. Monitor diagnostic reports from Pediatric Audiologists conducting diagnostic evaluations on infants not passing their newborn hearing screenings in order to meet the goal of identifying permanent hearing loss by three months of age. | | X | | |
| 3. Identify pediatric audiologists providing follow-up diagnostic evaluations and other services for non-pass UNHS infants. | | | | X |
| 4. The RIHPs track non pass referrals and provide early intervention services for infants identified with permanent childhood hearing loss. | X | | | |
| 5. The Infant Hearing Program, with input from the Advisory Subcommittee and the Genetics Program, continues to participate in collaborative initiatives. | | | | X |
| 6. | | | | |
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**b. Current Activities**
National 12 Current Activities

No changes have been made for the NPM for Infant Hearing screening.

**c. Plan for the Coming Year**
Percent of newborns screened for hearing before hospital discharge

A. Monitor birthing hospitals, free standing birthing centers, children's hospitals, and local health departments to ensure that complete and accurate data for newborn hearing screenings are reported to the Ohio Department of Health.

Activities
1. Monitor IPHIS and Hi*Track data for timeliness, accuracy and completeness.
2. Monitor hospital UNHS referral rates and missed screenings.
3. Provide targeted Technical Assistance as needs are identified.
4. Monitor local health department compliance with UNHS requirements.

B. Match comprehensive diagnostic evaluations received to non-pass results to identify infants receiving a hearing evaluation by three months of age; monitor tracking and follow-up of infants with non-pass results to reduce numbers lost to follow-up.

Activities
1. Review and forward diagnostic audiology reports for non-pass infants to RIHPs.
2. Monitor and educate pediatric audiologists and medical providers regarding recommended evaluation protocols and reporting requirements.
3. Monitor RIHP tracking and follow-up to ensure non-pass infants receive evaluations and referrals in accordance with protocols.

C. Promote awareness of early intervention and work collaboratively with professionals to provide early diagnosis (by 3 months of age) and intervention (by 6 months of age) for infants identified with a permanent childhood hearing loss.

Activities
1. Survey pediatric diagnostic audiologists annually and update directory.
2. Support SKI*HI training for RIHP service providers.
3. Continue outreach to professionals and primary care providers.
4. Prepare and disseminate an Annual Report to the state legislature and stakeholders.

D. Identify program strengths and weaknesses. Utilize public health and professional community resources to assist in addressing identified program weaknesses.

Activities
1. Meet regularly with the UNHS Advisory Subcommittee to identify and address program strengths, weaknesses, and resources for improvement.
Collaborate with stakeholder groups to improve program outreach, implement collaborative activities, and strengthen loss to follow up initiatives.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 7.5 | 7 | 7 | 7 | 7.5 |
| Annual Indicator | 7.1 | 7.1 | 7.3 | 8.5 | 8.5 |
| Numerator | 198000 | 198000 | 199000 | 229500 | 229500 |
| Denominator | 2787000 | 2787000 | 2734000 | 2702500 | 2702500 |

| | | | | | |
|---|---|---|---|---|---|
| Data Source | | Current Population Survey | Current Population Survey | Current Population Survey | Current Population Survey |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 7.5 | 8.5 | 8 | 7.5 | 7 |

**Notes - 2011**
Provisional 2011 Data for the FFY2013 BG Report will be entered based on the Final 2010 Data

**Notes - 2009**
The 2009 data is provisional from the 2009 Annual Population Survey Report. We will finalize the 2009 data in the next FY.

**a. Last Year's Accomplishments**
The target for CY2010 was 7.5%. The actual percent of children without health insurance was 8.5%, higher than reported for CY2009 (7.2%). Ohio did not meet its target.

Strategy 1: Monitor data regarding the rate of uninsured children

US Census Bureau data were used to calculate the rate of uninsured children in Ohio which is 8.5% (numerator = 229,500 (2 yr. average & denominator is 2,702,500).

According to the 2010 Ohio Family Health Survey, 19.0% of Ohio's children were without dental insurance coverage (486,000). The percentage of Ohio's children without dental coverage decreased from 22.9% in 2004 to 18.3% in 2008, but rose slightly in 2010 to 19.0%. The proportion of Ohio's children without dental insurance coverage remains more than 4 times the proportion of children without medical coverage (4.6% in 2010).

DFCHS programs report varying statistics for the number of uninsured children served: Child and Family Health Services program indicated that 11% (5703) of all visits were with un/underinsured children; Primary Care and Rural Health programs report almost 70,000 children were seen through their free clinics and community health centers.

Strategy 2: Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to access and navigate the public health care system

Information on how to apply for Medicaid/Healthy Start (HS) was provided to low-income families through 18 school-based dental sealant programs, 20 dental safety net programs; four dental OPTIONS programs; 59 Child and Family Health Services programs; and 220 local WIC clinics. These program providers and consumers receive training and technical assistance from DFCHS staff on how to understand and navigate the health care system.

Critical Access Hospitals (CAH) in 34 rural communities, 150 Federally Qualified health Center (FQHC) sites in 36 rural and urban counties; and 40 Free clinic sites in 51 counties worked to enroll children and families into Medicaid/HS and to help providers and consumers understand and navigate the health care system.

BCMH participates as one of the agencies providing input to ODJFS regarding the special needs, services, characteristics, and care coordination strategies for CSHCN transitioning from Medicaid fee-for-service to the Medicaid managed care delivery system.

BCMH staff provided training and technical assistance to public health nurses (PHNs) and providers, HMG social workers & service coordinators to assure comprehensive and efficient medical services to BCMH families.

BCMH provides financial assistance to hospital- based service coordinators to assist families in coordinating medical care by specialists.

Medicaid Administrative Claiming (MAC) data indicates that BCMH staff spends approximately 59% of their time referring, facilitating, monitoring and coordinating, Medicaid activities for families of children with special health care needs.

Help Me Grow Home Visitors (HV) work with low income, Medicaid eligible first time or expectant parents. HV connected 6,000 children to Medicaid/HS or other insurance and a patient-centered medical home.

Strategy 3: Promote enrollment in SCHIP (Healthy Start) and other policy changes that lead to more kids/families being covered consistently and adequately (i.e., presumptive, continuous, express lane eligibility) through public health agencies, schools.

Oral Health worked with the Children's Oral Health Action Team (COHAT) and the Ohio Dental Association to educate legislators about the importance of maintaining adult dental benefits in the state Medicaid program. The efforts were successful as the adult dental benefit was maintained in the biennial budget.

The interagency, Combined Programs Application form is used to assist families in accessing DFCHS programs. WIC served an average of 281,306 participants in federal fiscal year 2011.

BCMH participates in Voices for Ohio's Children coalition to promote simplification of Medicaid enrollment and retention, including presumptive eligibility, 12 month continuous coverage for kids and express lane eligibility.

BCMH supports linking children with special health care needs to Medicaid programs by paying Medicaid spend down payments, Medicaid- Buy- for Workers with Disabilities premiums and Medicare part B premiums.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Monitor data regarding the rate of uninsured children | | | | X |
| 2. Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to access and navigate the public health care system | | | X | |

| | | | | |
|---|---|---|---|---|
| 3. Promote enrollment in SCHIP (Healthy Start) and other policy changes that lead to more kids/families being covered consistently and adequately (i.e., presumptive, continuous, express lane eligibility) through public health agencies, schools. | | | | X |
| 4. | | | | |
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**b. Current Activities**
NPM#13 has not changed any of the strategies.

**c. Plan for the Coming Year**
Annual Plan for 2012 (10/1/12-9/30/13)
A. Monitor data regarding the rate of uninsured children (infrastructure level strategy)
• Report health insurance data from the National Current Population Survey and Ohio's Medicaid Assessment Survey (formerly Family Health Survey), and DFCHS programs, if applicable.
• Develop a communication plan to disseminate results of the Medicaid Assessment Survey detailed analyses and how they were used to benefit programs.

B. Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to access and navigate the public health care system ( population-based and infrastructure level strategy).
• Provide health insurance information/materials (e.g., Benefit Bank, Help Me Grow Wellness Guide, direct mailings, program meetings, trainings, and/or conferences) to public and private sector providers, including child care health consultants, public health nurses, ODH subgrantees (e.g., local health departments, FQHCs, rural hospitals), general public, families of CSHCN, and parent advocacy groups via DFCHS programs (BCFHS, BCMH/EI, BCHS, BNS).
• Implement and monitor the ODH/Medicaid Interagency Agreement (IAA deliverables containing provisions regarding Medicaid enrollment, outreach and training activities.
• Promote the use of Medicaid Administrative Claiming (MAC) in local health departments to improve access to Medicaid coverage and the use and delivery of Medicaid-covered services.

C. Promote enrollment in SCHIP (Healthy Start) and other policy changes that lead to more kids/families being covered consistently and adequately (i.e., presumptive eligibility for pregnant women and children; family planning eligibility, continuous, express lane eligibility) through public health agencies, schools and school-based programs (enabling level strategy).
• Coordinate efforts with Office of Ohio Health Plans (Medicaid) to conduct outreach and enrollment of children in Medicaid programs.
• Provide information and updates regarding SCHIP enrollment via new school nurse orientation trainings and the annual regional school health conference for the purpose of assisting school nurses in conducting outreach for Healthy Start.
• Provide trainings to local public health nurses, directors of nurses and hospital based service coordinator through education days and regional meetings.
• Provide routine information on outreach and enrollment through the Director of Nurses and Public Health Nurses list serve.
• Establish links to SCHIP and other programs for outreach and enrollment activities via ODH website and ODH program web pages.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 26.6 | 26.6 | 26.1 | 26.1 | 25.6 |
| Annual Indicator | 27.6 | 28.0 | 28.0 | 28.2 | 28.2 |
| Numerator | 32132 | 35003 | 37078 | 36309 | 36309 |
| Denominator | 116418 | 125011 | 132423 | 128754 | 128754 |
| Data Source | | CDC PedNSS | CDC PedNSS | CDC PedNSS | CDC PedNSS |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 25.6 | 25.6 | 26.1 | 26.1 | 26.1 |

**Notes - 2011**
Provisional 2011 Data for FFY2013 based on Final 2010 Data

**Notes - 2010**
After rising for more than 2 decades, overweight and obesity rates within these children appear to be leveling off in the pas t 3 years at around 28%. However, ethnic disparities persist, with Hispanics having a rate of 35.5% in 2010 compared to 28.3% for non-Hispanic white children and 25.2% among non-Hispanic Black children.

**Notes - 2009**
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

**a. Last Year's Accomplishments**
Percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
10/1/10 through 9/31/11

Goal: To reduce the proportion of children, ages 2 to 5 years, who are at risk for overweight or obesity.

A. Inventory of statewide resources/programs (Infrastructure): Collected data from local WIC subgrantees on all new and/or revised referral resources for overweight.
Collaborate with ODH Healthy Ohio in using the inventory data (Infrastructure): Not met.
Analyze data from the WIC participant survey (Infrastructure): Analysis was completed on the 2010 survey and analysis was begun on the 2011 survey.
Assist as needed on the ODH 3rd grade Obesity Report (Infrastructure): Local WIC staff volunteered their time to assist with data collection.

B. Distribution of educational pieces related to Value Enhanced Nutrition Assessment (VENA) (Infrastructure): Email communication on VENA related topics were distributed.

Provide advanced education topics to staff (Infrastructure): An educational training via the Ohio TRAIN system was offered on infant and child formulas.

C. Collaboration with the ODH office of Healthy Ohio obesity coordinator (Infrastructure): WIC served a representative on the Community Wellness Alliance (CWA) which is working on the Obesity Report.
Serve on the Ohio AAP advisory committee for the Ounce of Prevention grant (Infrastructure): WIC continued to represent on an as needed basis.
Partner and collaborate on the SNAP for Education committee (Infrastructure): WIC continued to represent on an as needed basis.

D. Explore the creation of a WIC Obesity Taskforce (Infrastructure): Revision of the WIC Nutrition Education Plan was set as a Goal for the 2001/2012 fiscal years and is currently in process.

E. Reevaluate the WIC participant survey (Infrastructure): The 2012 Participant Survey was revised to include questions on the new Nutrition Kiosks in local WIC clinics. This data will be used to create Ohio specific online nutrition education modules for use with the kiosks.
Begin the planning process for the next phase of the "WIC Activity Box" Pilot (Infrastructure): On hold until the data analysis from the first pilot is completed.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Inventory of statewide resources/programs | | | | X |
| 2. Distribution of educational pieces related to Value Enhanced Nutrition Assessment (VENA) | | | | X |
| 3. Collaboration with the ODH office of Healthy Ohio obesity coordinator | | | | X |
| 4. Explore the creation of a WIC Obesity Taskforce | | | | X |
| 5. Reevaluate the WIC participant survey | | | | X |
| 6. | | | | |
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| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
No strategies have changed

**c. Plan for the Coming Year**
Percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile. 10/1/12 through 9/30/2013

Goal: To reduce the proportion of children, ages 2 to 5 years, who are at risk for overweight or obesity.

Strategies for year 6:
A. Conduct data surveillance and monitoring activities.
Activities in year 6:
1. Continue to conduct and support the inventory of statewide resources/programs addressing the treatment of childhood obesity (Obesity Inventory Tool) as necessary through WIC clinics, CFHS projects, and Rural Health programs.

2. Work with the ODH Bureau of Prevention in using the inventory data.
3. Collect data from the WIC participant survey.
4. Explore ways to build capacity for data with the discontinuation of PedNSS.

B. Increase WIC staff education and involvement in prevention and treatment initiatives.
Activities in year 6:
1. Continue to distribute educational pieces on topic such as cultural competency and critical thinking to local WIC staff to continue the foundation established with the Value Enhanced Nutrition Assessment (VENA) training.
2. Provide advanced education topics via the Health Professional newsletter to staff related to new breastfeeding guidelines.

C. Explore new opportunities for collaboration.
1. Continue collaboration with the ODH Bureau of Prevention obesity coordinator to support the state obesity plan.
2. Continue to serve, as needed, on the Ohio American Academy of Pediatrics advisory committee for the Ounce of Prevention promotion grant.
3. Seek for partnership and collaboration opportunities by serving on the Supplemental Nutrition Assistance Program for Education committee for partnership, information, and education resources.
4. Collaborate with Help Me Grow and Early Care and Education as needed.

D. Evaluate WIC efforts to impact overweight.
1. Continue to reevaluate the WIC participant survey to gather data on participant perception of weight, WIC obesity intervention and healthy eating behavior.
2. With OA grant funding, use texting as a means to promote nutrition education.
3. Revise the Ohio WIC Nutrition Education plan for addressing childhood overweight.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 19 | 14 | 14 | 14 | 18.5 |
| Annual Indicator | 15.9 | 19.2 | 19.2 | 14.8 | 14.8 |
| Numerator | 23295 | 28363 | 27537 | 20122 | 20122 |
| Denominator | 146739 | 147410 | 143547 | 136196 | 136196 |
| Data Source | | Ohio Vital Statistics | Ohio vital Statistics | Ohio Vital Statistics | Ohio Vital Statistics 2010 final birth file |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 13 | 13 | 13 | 13 | 13 |

**Notes - 2011**
2011 Provisional data for FFY2013 reported from 2010 final birth file.

**Notes - 2010**
Update from Data Narrative: Prior to 2010, the information reported for this indicator was calculated as the percentage of births with any maternal smoking during pregnancy. This was corrected for 2010 data to include only mothers who reported smoking during the last trimester. Thus, the observed decline in 2010 was largely due to a correction in the way the indicator was calculated.

**Notes - 2009**
The 2009 data is currently not available. 2008 data has been used as as estimate for 2009.

**a. Last Year's Accomplishments**
Accomplishments: October 1, 2010-September 30, 2011 - Data being provided by ODH Epidemiologist

A. Build the capacity of MCH healthcare systems to support the 5 A's evidence-based smoking cessation intervention & assist MCH practitioners integrate the 5 steps Ask-Advise-Assess-Assist-Arrange as a standard of care (USPHS Treating Tobacco Use & Dependence Guidelines).

This infrastructure-level strategy will be accomplished through the following activities: Assess the MCH healthcare systems (i.e., WIC, CFHS) capacity to support evidence-based smoking cessation intervention; assess provider (i.e., WIC, CFHS) awareness of evidence-based smoking cessation interventions; ensure that healthcare systems are in place to screen women for tobacco use & offer treatment; & ensure that practitioners have the tools, training & technical assistance needed to treat smokers effectively.

Accomplishments: OPSFF expanded the WIC initiative from 23 to 29 volunteer sites. Beginning July 2011, CFHS agencies receiving ODH funds to provide perinatal direct care services were required to provide the 5 A's intervention. By October 2011, 12 of 14 CFHS grantee agencies began the process of integrating the 5 A's into routine perinatal care. Both WIC & CFHS clinic sites were assessed; training & technical assistance was provided to ensure the 5 A's intervention & documentation was performed at each clinic site. Chart audits indicated at some sites either the systems in place did not prompt the providers to provide all 5 A's or the providers did not properly document the 5 A's. Refresher trainings were conducted & plans were developed to modify client records to electronically document the 5 A's intervention. This automated data system will be used as a monitoring tool to provide immediate feedback to sites. In addition, the GSIP Intern conducted an evaluation of the OPSFF Initiative in WIC Clinics to determine: if the 5A's intervention could be integrated into an already existing system; & if the 5 A's is being delivered as planned. Preliminary findings from baseline chart review & the pilot outcomes were promising. Evaluation is ongoing.

B. Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second & third-hand smoke.

This infrastructure-level strategy will be accomplished through the following activities: Assess the healthcare systems (i.e., CFHS) capacity to support environmental health risk reduction; assess provider (i.e., CFHS) awareness of environmental health risks; ensure that systems are in place to screen women for environmental health risks; ensure that practitioners have the tools, training & technical assistance; & ensure women have access to information that will help them take action to reduce environmental exposures.

Accomplishments: Beginning July 2011, CFHS agencies receiving ODH funds to provide perinatal direct care services are required to screen perinatal clients for environmental health risks. Plans were developed to incorporate Healthy Homes (CDC funded program) into CFHS by: revising CFHS perinatal standards for perinatal providers & community health workers to include "Healthy Homes" guidelines; & disseminate Healthy Homes DVD (produced by ODH Lead Program) to increase consumer awareness of common health homes issues.

C. Engage partners to address tobacco use & dependence among women of reproductive age, including pregnant women.

This infrastructure-level strategy will be accomplished through the following activities: Promote evidence-based smoking cessation interventions; collaborate with partners & leverage resources; participate/facilitate workgroups to address tobacco use & dependence.

Accomplishments: Workgroups comprise of public-private health providers, businesses, government agencies, faith-based organizations, advocacy groups & consumers from across the state. Infant Mortality collaborative formed in 2010 meets quarterly & aims to reduce Ohio's infant mortality & birth-outcome disparities. Tobacco Free alliance meets quarterly to share resources & is committed to eliminating the use of tobacco products. Birth Defects Prevention partners meet quarterly & are committed to promoting preconception health & educating about birth defects.
D. Incorporate culturally appropriate activities & interventions-refer to activities in State Performance Measure 04.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Build the capacity of MCH healthcare systems to support the 5 A's evidence-based smoking cessation intervention & assist MCH practitioners integrate the 5 steps Ask-Advise-Assess-Assist-Arrange as a standard of care (USPHS Treating Tobacco Use & Depe | | | | X |
| 2. Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second & third-hand smoke. | | | | X |
| 3. Engage partners to address tobacco use & dependence among women of reproductive age, including pregnant women. | | | | X |
| 4. Incorporate culturally appropriate activities & interventions-refer to activities in State Performance Measure 04. | | | | X |
| 5. | | | | |
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| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
No strategies for NPM 15 FFY 12 Current Year Plan have been completed, revised, or dropped at this time.

**c. Plan for the Coming Year**
A. Build the capacity of MCH healthcare systems to support the 5 A's evidence-based smoking cessation intervention and assist MCH practitioners integrate the 5 steps Ask-Advise-

Assess-Assist-Arrange as a standard of care (USPHS Treating Tobacco Use and Dependence Guidelines).
Ohio Partners for Smoke-Free Families will accomplish this through the following activities: Assess the MCH healthcare systems (i.e., WIC, CFHS) capacity to support evidence-based smoking cessation intervention; assess provider (i.e., WIC, CFHS) awareness of evidence-based smoking cessation interventions; ensure that healthcare systems are in place to screen women for tobacco use and offer treatment; ensure that practitioners have the tools, training and technical assistance needed to treat smokers effectively.

B. Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second and third-hand smoke.
Child and Family Health Services will accomplish this through the following activities: Assess the healthcare systems (i.e., CFHS) capacity to support environmental health risk reduction; assess provider (i.e., CFHS) awareness of environmental health risks; ensure that systems are in place to screen women for environmental health risks; ensure that practitioners have the tools, training and technical assistance; and ensure women have access to information that will help them take action to reduce environmental exposures.

C. Engage partners to address tobacco use and dependence among women of reproductive age, including pregnant women.
The Perinatal Smoking Cessation Program will accomplish this through the following activities: Promote evidence-based smoking cessation interventions; collaborate with partners and leverage resource; use the media effectively; convene and facilitate or participate in the following workgroups to address tobacco use and dependence: Ohio Collaborative to Prevent Infant Mortality; MCH Block Grant Performance Measure 15 Workgroup, Tobacco Free Ohio Alliance and Ohio Partners for Birth Defects Prevention. Current smoking data from Ohio's Pregnancy Risk Assessment Monitoring System (PRAMS) and Ohio Behavioral Risk Factor Surveillance Survey (BRFSS) reflecting trends will be shared with these partners.

D. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.
Vital Stats data show that smoking during pregnancy has not improved in Ohio in recent years. Native American and multiracial women had higher percentages of smoking during the last trimester of pregnancy than other racial groups. Data from PRAMS show that women who received Medicaid were more likely to smoke during the last three months of pregnancy than those who did not receive Medicaid. Modifications to the current activities may be adjusted based on those results.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 8.5 | 8.5 | 7 | 7 | 7 |
| Annual Indicator | 7.5 | 10.3 | 9.0 | 7.4 | 7.4 |
| Numerator | 61 | 83 | 73 | 61 | 61 |
| Denominator | 811659 | 809174 | 810191 | 823682 | 823682 |
| Data Source | | Ohio Vital Statistics | Ohio Vital Statistics US Census Bureau 2009 | Ohio Vital Statistics | Ohio Vital Statistics US Census Ohio population |

| | | | | | |
|---|---|---|---|---|---|
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 7 | 6.5 | 6.5 | 6 | 6 |

**Notes - 2011**
2011 Provisional data for 2011 reported from 2010 final mortality file.

I do not believe Ohio should project much lower than 6.5 for 2013 as our numbers are small and the interventions have not increased.

**Notes - 2010**
Provisional 2009 data entered for FFY2011 was based on Final 2008 data. Provisional 2010 data for FFY12 will be entered based on the Final 2009 Data unless 2010 Data is available and provided.

**Notes - 2009**
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

**a. Last Year's Accomplishments**
The ODH Adolescent Health Council prioritized mental health/suicide prevention as one of the top 5 health issues to address in the Ohio Adolescent Health strategic plan. Data was shared on the issue to help inform the work of the Council. A fact sheet was created on adolescent injury data which included suicide fact sheet. Fact sheet is accessible at: http://www.odh.ohio.gov/ASSETS/DB07E0D8E2EC4D899001999CAFBE561C/Suicide%20Deaths.pdf . In addition data from the 2011 YRBS Ohio's YRBS 2011 data reveals that 27% of Ohio's teens felt depressed and approximately 14% made a suicide plan. Nine percent of Ohio's teens actually attempted suicide. Data from CFR was shared with the Council as well indicating that over a 4 year period of time (2005-2009) 178 deaths were a result of suicide for teens ages 15-17 years. The data fact sheets were duplicated and disseminated among adolescent health care providers within the 5 Children Hospital's of the state as well as other state agencies and stakeholders. Data on suicide was also shared at the annual Ohio Prevention Education Conference.

B. ODH's Adolescent and School health program have worked with the Ohio Dept. of Education to support TA to schools and communities on Bullying efforts as the data indicates that many of the teens who are depressed are also victims of bullying. Training of school nurses on cyber bullying and signs and symptoms of depression was done during the regional school nurse trainings with over 700 school nurses attending and receiving the information. The Ohio Suicide Prevention Foundation recently received a grant and has plans that impact adolescents. They're activities are called Ohio's Campaign for Hope. One component is to provide high school teachers/staff with a one-hour, online, free Kognito Gatekeeper training. Another component is to provide funding for suicide prevention activities for 26 at-risk counties with higher than state and national youth suicide rates. The Adolescent Health Council will continue to partner with the Ohio

Suicide Prevention Foundation to disseminate information through this campaign to schools and communities.

C. ODH's school and adolescent health program has and continues to collaborate with other state agency such as the Ohio department of Mental Health (ODMH) on this issue. The ODH/School and adolescent Health program has been added as a member of the planning group on the new ODMH federal grant ENGAGE which will assessing resources at the local level to help increase support for mental health services for children and teens. Additionally new collaboration has occurred this year with the Ohio Department of Jobs and Family Serivces and Youth Services providing specialized training for direct care staff who work with youth in residential settings and foster care homes. Through a federal grant received by ODH school and adolescent health program Personal Responsibility Education Program (PREP), resources are being invested into developing a curriculum that focuses on prevention education specifically for teen pregnancy, STD prevention and successful transition into adulthood for high risk youth. The program is a train the trainer model providing professional development that will increase the skills of staff who work with these youth on a daily basis. Included in this training was A 2 day mental health program provided through an MOU with DYS. The training provided information on cognitive behavioral therapy, signs and symptoms of depression and ways to reinforce positive behavior that decrease depression and increase the likelihood that these youth will successfully transition into adult hold. Once staff has been trained they will begin working directly with youth in those systems over the next 5 years.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The ODH Adolescent Health Council prioritized mental health/suicide prevention as one of the top 5 health issues to address in the Ohio Adolescent Health strategic plan. | | | | X |
| 2. ODH's Adolescent and School health program have worked with the Ohio Dept. of Education to support TA to schools and communities on Bullying efforts as the data indicates that many of the teens who are depressed are also victims of bullying. | | | | X |
| 3. ODH's school and adolescent health program has and continues to collaborate with other state agency such as the Ohio department of Mental Health (ODMH) on this issue. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Strategies

A. Use data, including Child Fatality Review, Youth Risk Behavior Survey, Vital Statistics and Ohio Hospital Data, to describe problems of youth suicide in Ohio.

B. Working with the ODMH supporting the ENGAGE Project.

C. Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide school based strategies.

D. Participate and support the Ohio School Health Care Association Steering Committee.

**c. Plan for the Coming Year**
The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Strategies
A. Use data, including Child Fatality Review, Youth Risk Behavior Survey, Vital Statistics and Ohio Hospital Data, to describe problems of youth suicide in Ohio, and then share results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health and the ODH Adolescent Health Advisory Group. A fact sheet was created on adolescent injury data which included suicide fact sheet. Fact sheet is accessible at:
http://www.odh.ohio.gov/ASSETS/DB07E0D8E2EC4D899001999CAFBE561C/Suicide%20Deaths.pdf

B. Working with the ODMH supporting the ENGAGE Project, a one year SAMHSA planning grant. ODH will be collaborating with ODMH, ODJFS and OFCF as well as communities and families to develop a one year cross systems strategic plan to address the mental health needs of youth in transition.

C. Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide school based strategies. This strategy is being accomplished by continuing to collaborate with our partners through the work of the Ohio Suicide Prevention Foundation Advisory Committee, the Ohio Mental Health Network, and the ODE. Information will be shared with school personnel through the ODH school health conferences and trainings.

D. Participate and support the Ohio School Based Health Care Association. Promote data on mental health needs of adolescents with Ohio school based health care providers.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 74 | 74 | 74 | 74 | 74 |
| Annual Indicator | 69.8 | 69.3 | 70.3 | 69.3 | 69.3 |
| Numerator | 1779 | 1659 | 1665 | 1623 | 1623 |
| Denominator | 2550 | 2393 | 2368 | 2342 | 2342 |
| Data Source | | Ohio Vital Statistics | Ohio Vital Statistics | Ohio Vital Statistics | Ohio Vital Statistics 2010 final birth file |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3- | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 74.5 | 75 | 75.5 | 76 | 76 |

**Notes - 2011**
2011 provisional data for 2011 reported from 2010 final birth file

**Notes - 2010**
Provisional 2009 data entered for FFY2011 was based on Final 2008 data. Provisional 2010 data for FFY12 will be entered based on the Final 2009 Data unless 2010 Data is available and provided.

**Notes - 2009**
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

**a. Last Year's Accomplishments**
Preliminary 2010 data show that for all births where birth weight data were available there were a total of 2334 very low birth weight births (defined as less than 1500 grams). Of these VLBW births, 1623 occurred in level three hospitals (using 2008 hospital level designation data). This resulted in 69.54% of VLBW births occurring in level 3 hospitals.
1623 VLBW births in level 3 hospitals / 2334 VLBW births = 69.54% of all VLBW births occurred within level 3 hospitals
A. Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities.

Accomplishments: An epidemiologist position was vacant through much of the FFY and these analyses were not accomplished. Recently, a new epidemiologist, Sara Miller, was hired and this is her first major assigned project.

B. Fund, monitor and evaluate DCFHS programs designed to take data to action.

Accomplishments:
1) ODH, along with the state ODJFS Medicaid office, has developed a project that will, through the use of improvement science, reduce preterm births and improve outcomes of preterm newborns as quickly as possible. Efforts to support the improvement activities include the development of a statewide network infrastructure designed to use health care quality improvement science to improve the delivery of health care to pregnant women and children resulting in improved outcomes of care and cost efficiency for neonates, infants, and older children. The infrastructure includes creation of a state level core team of clinical quality improvement specialists; a number of local Regional Coordinators (RCs) and a data development infrastructure. In FY11, perinatal projects focus on reducing bloodstream infections in hospitalized premature infants (24 NICUs) and near term deliveries without medical indications (20 OB units). These projects reduced infections and NICU admissions with an estimated savings to Ohio of at least $11 million in annual total costs.
2) One of the key recommendations of the Infant Mortality Task Force was the establishment of a permanent statewide body to continue the work of the task force. To address this recommendation, ODH, together with key partners from the task force, established the Ohio Collaborative to Prevent Infant Mortality. ODH supports the collaborative with a .48 FTE program consultant as well as staff membership/participation in all of the organization's five work groups and the executive/steering committee. ODH has helped the collaborative develop a regular meeting schedule, public and private Web sites, educational/outreach materials and provides epidemiological and data services support. ODH has secured the services of Dr. Arthur James, MD, a well-known obstetrician and national expert in the impact of racism on infant mortality. Dr.

James serves a Senior Policy Advisor at ODH and as co-chair of the Collaborative.
Another key strategy in the task force report was the implementation of a Medicaid family planning waiver to extend reproductive health care coverage to low-income Ohioans who do not meet current Medicaid income guidelines. This amendment was approved at the federal level for January 2, 2012 and is currently being implemented by our sister agency, the Ohio Department of Job and Family Services, Office of Ohio Health Plans.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities. | | | | X |
| 2. Fund, monitor and evaluate DCFHS programs designed to take data to action. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
No changes to Current Activities

**c. Plan for the Coming Year**
A. Continue to analyze and identify data trends pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities.

This infrastructure-level strategy will be accomplished by: 1) developing web-based regional perinatal reports that include information about preterm birth and the percent of babies by birthweight born in hospital identified by level designation; 2) further analyzing this data to drive programmatic decisions; 3) presenting the data to the Ohio Collaborative to Prevent Infant Mortality: and 4) working with Division of Quality Maternity Licensure Unit to use data to strengthen licensure rules and enforcement.

B. Fund, monitor and evaluate DCFHS programs designed to take data to action.

This infrastructure-level strategy will be accomplished by: 1) continuing to partner with ODJFS to implement quality improvement activities among local maternal and child health providers and 2) aligning DCFHS programs, including programs serving pregnant women and maternity licensure, to implement the recommendations identified in Preventing Infant Mortality in Ohio: Task Force Report

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 88.5 | 80.5 | 80.5 | 80.5 | 75 |
| Annual Indicator | 70.7 | 69.7 | 70.2 | 73.0 | 73.0 |
| Numerator | 82438 | 77693 | 76485 | 78416 | 78416 |
| Denominator | 116582 | 111478 | 108992 | 107489 | 107489 |
| Data Source | | Ohio Vital Statistics | Ohio Vital Statistics | Ohio Vital Statistics | Ohio Vital Statistics 2010 final birth file |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 75 | 76 | 76 | 76 | 76 |

**Notes - 2011**
2011 provisional data for 2011 reported from 2010 final birth file.

**Notes - 2010**
Provisional 2009 data entered for FFY2011 was based on Final 2008 data. Provisional 2010 data for FFY12 will be entered based on the Final 2009 Data unless 2010 Data is available and provided.

**Notes - 2009**
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

**a. Last Year's Accomplishments**
Preliminary 2010 data shows that for all births where the month of first prenatal visit was known a total of 107,027 births occurred in 2010. 78,097 births received prenatal care in the first trimester resulting in 72.97% of births having received prenatal care within the first trimester of pregnancy. 78,097 births with first trimester prenatal care / 107,027 births with known values for prenatal care = 74.97% of births received first trimester prenatal care
A. Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests. Identify trends, opportunities for technical assistance and/or intervention and recommend follow-up activities.

Accomplishments: Because the Family Planning program was undergoing a major consolidations and entering into a new competitive cycle, no specific data analysis was done on intendedness, perinatal depression/mental health. However, to facilitate pre/interconception service protocols for public health programs in FY12 the RHWP program gave the opportunity for sub-grantees to apply for enhanced funds to 1) provide evidence based comprehensive reproductive health and wellness education to reproductive aged males and/or to promote the establishment of a reproductive life plan for all RHWP patients.

B. Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity.

Accomplishments: An epidemiologist position was vacant through much of the FFY and these analyses were not accomplished. Recently, a new epidemiologist, Sara Miller, was hired and this is will be one of her assigned projects.

C. Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs.

Accomplishments: This infrastructure-level strategy will be accomplished by working with SPM 4 Workgroup. See SPM 4 accomplishments..

D. Support the work of the consortium which formed as a result of the Preventing Infant Mortality in Ohio: Task Force Report.

Accomplishments:
1) ODH, along with the state ODJFS Medicaid office, has developed a project that will, through the use of improvement science, reduce preterm births and improve outcomes of preterm newborns as quickly as possible. Efforts to support the improvement activities include the development of a statewide network infrastructure designed to use health care quality improvement science to improve the delivery of health care to pregnant women and children resulting in improved outcomes of care and cost efficiency for neonates, infants, and older children. The infrastructure includes creation of a state level core team of clinical quality improvement specialists; a number of local Regional Coordinators (RCs) and a data development infrastructure. In FY11, perinatal projects focus on reducing bloodstream infections in hospitalized premature infants (24 NICUs) and near term deliveries without medical indications (20 OB units). These projects reduced infections and NICU admissions with an estimated savings to Ohio of at least $11 million in annual total costs.
2) One of the key recommendations of the Infant Mortality Task Force was the establishment of a permanent statewide body to continue the work of the task force. To address this recommendation, ODH, together with key partners from the task force, established the Ohio Collaborative to Prevent Infant Mortality. ODH supports the collaborative with a .48 FTE program consultant as well as ongoing staff support for work groups. ODH has helped the collaborative with logistical support and provides epidemiological and data services support. ODH has secured the services of Dr. Arthur James, MD, a well-known obstetrician and national expert in the impact of racism on infant mortality who serves a Senior Policy Advisor at ODH and as co-chair of the Collaborative.
Another key strategy in the task force report was the implementation of a Medicaid family planning waiver to extend reproductive health care coverage to low-income Ohioans who do not meet current Medicaid income guidelines. This amendment was approved at the federal level for January 2, 2012 and is currently being implemented by our sister agency, the Ohio Department of Job and Family Services, Office of Ohio Health Plans.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests. Identify trends, opportunities for technical assistance and/or intervention and recommend follow-up activities. | | | | X |
| 2. Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity. | | | | X |
| 3. Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs. | | | | X |
| 4. Support the work of the consortium which formed as a result of the Preventing Infant Mortality in Ohio: Task Force Report. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

No changes in current activities

**c. Plan for the Coming Year**

A. Improve the rate of Medicaid coverage for eligible women and men by promoting newly approved presumptive eligibility for pregnant women and the expansion of coverage for family planning services under Medicaid.

This infrastructure-level strategy will be accomplished by: 1) working with ODJFS and family planning and prenatal partners to develop and distribute outreach materials; 2) distributing outreach materials to providers and other stakeholders statewide and 3) posting information and links to Medicaid on ODH website.

B. Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity.

This infrastructure-level strategy will be accomplished by: 1) gathering and analyzing data about first trimester entry into prenatal care in BCFHS funded programs by age, marital status, income, education, parity, payer, race and ethnicity; 2) reviewing literature of evidence-based practices on getting women into prenatal care in the first trimester; 3) providing technical assistance to BCFHS funded programs to gather data on entry into prenatal care (specifically in Early Track) and strengthen referral and follow-up to activities between family planning services and prenatal care services and to ensure education to women about the importance of early entry into prenatal care based on data.

C. Provide training and/or technical assistance to increase strategic plans to increase Cultural

Competency in family planning and prenatal care services in DFCHS funded programs.

This infrastructure-level strategy will be accomplished by working with SPM 4 Workgroup. See SPM 4 work plan.

D. Support the work of the Ohio Collaborative to Prevent Infant Mortality.

This infrastructure-level strategy will be accomplished by: 1) continuing to partner with ODJFS to implement quality improvement activities among local maternal and child health providers and 2) aligning DCFHS programs to implement the recommendations identified in Preventing Infant Mortality in Ohio: Task Force Report. 3) Distribute the Action Learning Collaborative on Infant Mortality and Racism toolkit to local public health, private providers and community partners, through OhioTrain.

## D. State Performance Measures

**State Performance Measure 1:** *Statewide capacity to reduce unintended pregnancies among populations at risk for poor birth outcomes.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 4 |
| Annual Indicator | | | | 3 | 4 |
| Numerator | | | | 3 | 4 |
| Denominator | | | | 4 | 4 |
| Data Source | | | | PRAMS and VS | PRAMS and VS |
| Is the Data Provisional or Final? | | | | | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 4 | 4 | 4 | 4 | 4 |

**Notes - 2011**
Provisional 2011 data is based on final 2010 information.

**Notes - 2010**
2010 Data based on Ohio has been able to reach 3 of the 4 benchmarks for this state performance measure. A Family Planning Medicaid Waiver has not been implemented but a State Plan Amendment was sent to CMH at the end of 2010. Now that the data is available, the workgroup will determine other indicators in order to decrease the number of unintended pregnancies in Ohio.

Data Issues: This estimate assumes all abortions are the result of unintended pregnancy and that the proportion of fetal deaths which are unintended is the same as the proportion of live births. A small percentage of abortions will be due to fetal or maternal condition and not the result of an unintended pregnancy.

**Notes - 2009**
2009 Data based on Ohio has been able to reach 3 of the 4 benchmarks for this state performance measure.

**a. Last Year's Accomplishments**
SPM1: Statewide capacity to reduce unintended pregnancies among populations at risk for poor birth outcomes.

These infrastructure activities are ongoing and will continue to be monitored by the RHWP program.

A. List and report the populations at risk for poor birth outcomes among those who have unintended pregnancies. This list should not be limited to data that are readily available, but should also include indicators that require additional capacity to collect. This list will be shared with stakeholders, so as to make final recommendations.

The populations identified by the Reproductive Health & Wellness Program at risk for poor birth outcomes and unintended pregnancies include teens, minorities those under 100% of the Federal Poverty Level and the un/underinsured.

B. Identify gaps in the availability of data from the final list of populations and areas at risk for poor birth outcomes. Once these gaps are identified, RHWP will work to determine needs for additional resources, linking, and other activities to reduce unintended pregnancies among populations at risk for poor outcomes, promoting and supporting RHWP throughout the State of Ohio. Continue sustaining intra-agency partnerships to combine efforts to reduce infant mortality, reduce gestational diabetes and improve birth outcomes for high risk and at risk populations. Input for the Ohio Collaborative to Prevent Infant Mortality, the Ohio Diabetes Alliance, Text 4 Baby and the Office of Health Equity will be utilized.

Gaps in data are identified in PRAMS since only mothers having a live birth are captured. This does not include unintended pregnancies with outcomes such as abortion, miscarriage, or fetal death. An example of a way to work on this would be to look at abortion data from Vital Statistics. It is assumed that induced abortions were the result of an unintended pregnancy. Discussion about data from more than one source might give a better picture of women at higher risk for unintended pregnancy and poor birth outcomes.

RHWP and Bureau of Child & Family Health Services collaborate with programs and organization within and outside of ODH to work towards efforts to reduce poor birth outcomes. Collaborations include Gestational Diabetes Collaborative, Text 4 Baby, Breast & Cervical Cancer Program, Vaccines for Children Program, Infertility Prevention Project, Sexual Assault & Domestic Violence Prevention, Pregnancy Associated Mortality Review, March of Dimes, Medicaid Family Planning State Plan Amendment, Family & Children First, The American College of Obstetricians & Gynecologists, Maternal, Infant& Early Childhood Home Visiting program, Statewide Obesity Prevention Plan, Pregnancy Risk Assessment & Monitoring System, Children with Special Health Care Needs, The Ohio Collaborative to Prevent Infant Mortality, Office of Health Improvement, Perinatal Smoking Cessation Program and the Adolescent Health Program.

C. Assess the progress of methods to increase capacity and identify methods to implement and sustain activities and assure that programs provide culturally and linguistically appropriate services. A CLAS tool will be provided. Program reports and on-site monitoring will show adoption of CLAS. All RHWP nurses will be trained to provide intervention to teens reporting sexual coercion. Data on number of clients reporting sexual coercion, the number referred for services, and the total number served will be reviewed and assessed.

All RHWP agencies have been provided with Free Language Translation Service Posters and participate in tele-interpreting services, as needed. All agencies completed a Culturally&

Linguistically Appropriate Services in Health Care (CLAS) Strategic Plan as part of their application to the RHWP.

RHWP Consultants attended the Project Connect Family Planning & Adolescent Health Training of Trainers in October, 2011. Training was provided on how to identify sexual violence/coercion in the adolescent population, the impact of violence on reproductive and adolescent health, unique considerations for adolescents: developmental and integrated frameworks, and foundations for teaching the dynamics of sexual violence to adolescent health and family planning providers. Trainings have been scheduled for RHWP clinics in 2012.

This year, 359 patients reported sexual coercion while only 31 patients were referred for sexual coercion. RHWP served 47,792 patients in this time period.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. List and report the populations at risk for poor birth outcomes among those who have unintended pregnancies. | | | | X |
| 2. Identify gaps in the availability of data from the final list of populations and areas at risk for poor birth outcomes. | | | | X |
| 3. Assess the progress of methods to increase capacity and identify methods to implement and sustain activities and assure that programs provide culturally and linguistically appropriate services. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

A. The workgroup is actively working on this strategy.

B. The workgroup is actively working on this strategy.

C. This strategy has been revised to include the removal of the CLAS tool.

All Reproductive Health and Wellness Program nurses and staff will be trained to provide intervention to all men and women reporting sexual coercion. Data on number of clients reporting sexual coercion, the number referred for services, and the total number served will be reviewed and assessed.

**c. Plan for the Coming Year**

SPM1: Statewide capacity to reduce unintended pregnancies among populations at risk for poor birth outcomes.

Plan for the Coming Year
A. Monitor enrollees into the Medicaid Family Planning Expansion (Medicaid State Plan Amendment)

B. Work with Ohio Medicaid to provide education and outreach to consumers and providers regarding the Medicaid FP Expansion.

C. Ensure that all Reproductive Health and Wellness Program (RHWP) patients complete a Reproductive Life Plan.

D. List and report the populations at risk for poor birth outcomes among those who have unintended pregnancies.

E. Identify gaps in the availability of data from the final list of populations and areas at risk for poor birth outcomes.

F. Once these gaps are identified, Reproductive Health and Wellness Program will determine needs for additional resources, linking, and other activities to reduce unintended pregnancies among populations at risk for poor outcomes by promoting and supporting RHWP throughout Ohio.

G. Sustain intra-agency partnerships (Ohio Collaborative to Prevent Infant Mortality, the Ohio Diabetes Alliance, Text 4 Baby and the Office of Health Equity) to combine efforts to reduce infant mortality, reduce gestational diabetes and improve birth outcomes for high risk and at risk populations.

**State Performance Measure 2:** *Percent of low birth weight black births among all live black births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 13.4 |
| Annual Indicator | | 14.1 | 13.7 | 14.1 | 14.1 |
| Numerator | | 3683 | 3479 | 3123 | 3123 |
| Denominator | | 26091 | 25391 | 22192 | 22192 |
| Data Source | | Vital Statistics | Ohio Vital Statistics 2009 final birth files | Vital Statistics | Ohio Vital Statistics final birth file |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 13.3 | 13.2 | 13.1 | 13 | 13 |

**Notes - 2011**
2011 Provisional data for 2011 reported from 2010 final brith file.

**Notes - 2010**
Provisional 2010 data for FFY12 will be entered based on the Final 2009 Data unless 2010 Data is available and provided.

**Notes - 2009**
Final Data 2009

**a. Last Year's Accomplishments**
Preliminary data from 2010 show that for all births where race data for the mother was available there were a total of 23,411 black births. 3,233 of these black births had low birth weight (defined as weight less than 2500 grams). Therefore, 13.81% of black births had low birth weight.

3233 LBW black births / 23411 black births = 13.81% of all black births were of low birth weight
Strategy A: Assure that all DFCHS funded programs interacting with women of childbearing age focus on populations at greatest risk.

1. Evaluate programs interacting with women of childbearing age to identify their current interaction with populations at greatest risk.

Accomplishments:
The DFCHS has three programs, for a total of 276 projects awarded (SAAN) that interact with children of childbearing age who serve members from populations at greatest risk. A survey tool was developed to capture and enhance needed updated information about the profile of populations served by DFCHS programs. The tool has been piloted and is ready for distribution. See State Performance Measure 04 Accomplishments for more information.
The Child and Family Health Services (CFHS) program requires the population of interest continues to be low-income women and children in racial and ethnic groups that are disproportionately affected by poor health outcomes. The focus is on geographic areas and populations of highest need. The OIMRI component of CFHS continues to be focused on African-American populations at greatest risk of poor birth outcomes (e.g., low birthweight, infant mortality). Data on those populations served is reviewed on a regular basis and technical assistance is provided if high-risk populations are not being served.

2. Incorporate procedures to help local grantees further define and refine their focus on populations at greatest risk.

Accomplishments:
All applicant for subgrantee awards to ODH must submit a statement which outlines the intent of their application to address health disparities.
The CFHS program requires the population of interest continues to be low-income women and children in racial and ethnic groups that are disproportionately affected by poor health outcomes. The focus is on geographic areas and populations of highest need. The OIMRI component of CFHS continues to be focused on African-American populations at greatest risk of poor birth outcomes (e.g., low birthweight, infant mortality). Data on those populations served is reviewed on a regular basis and technical assistance is provided if high-risk populations are not being served.
CFHS and Reproductive Health and Wellness Program (RHWP) require CLAS Strategic Plan FY2011 Annual Progress Report that the project should describe the overall progress toward cultural competency.
The RHWP requires that all applicants must address the reproductive health and wellness needs of individuals, families, and communities through outreach to hard-to-reach and/or vulnerable populations, including partnering with other community-based health and social service providers that provide needed services. Data on those populations served is reviewed on a regular basis and technical assistance is provided if high-risk populations are not being served.

3. Supporting and including the work of the consortium, Ohio Collaborative to Prevent Infant Mortality, this formed as a result of the Preventing Infant Mortality in Ohio: Task Force Report.

Accomplishments and/or Work is in progress:

See accomplishments for National Performance Measure # 17, Strategy B, Accomplishment 2.
See accomplishments for National Performance Measure # 18, Strategy D.
See accomplishments for State Performance Measure # 04.

The 4 day Partners for Health Baby Curriculum Training was provided for all staff of the 14 Ohio Infant Mortality Reduction Initiative Programs. Each funded project serve African-American populations at greatest risk of poor birth outcomes (e.g., low birthweight, infant mortality).

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Evaluate programs interacting with women of childbearing age to identify their current interaction with populations at greatest risk. | | | | X |
| 2. Incorporate procedures to help local grantees further define and refine their focus on populations at greatest risk. | | | | X |
| 3. Supporting and including the work of the consortium, Ohio Collaborative to Prevent Infant Mortality, this formed as a result of the Preventing Infant Mortality in Ohio: Task Force Report. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
State Performance Measure 02: Percent of low birth weight black births among all live black births.

Strategy A: Assure that all DFCHS funded programs interacting with women of childbearing age focus on populations at greatest risk.

1. Evaluate programs interacting with women of childbearing age to identify their current interaction with populations at greatest risk.

2. Incorporate procedures to help local grantees further define and refine their focus on populations at greatest risk.

3. Supporting and including the work of the consortium, Ohio Collaborative to Prevent Infant Mortality, this formed as a result of the Preventing Infant Mortality in Ohio: Task Force Report.

Strategy B: Continue to refine RFPs and provide technical assistance to DFCHS funded program and Medicaid providers to ensure the target population is served.

1. Provide education to providers to conduct outreach to black women at high-risk of delivering a low birth weight baby.

2. Working with SPM 04 Workgroup. See SPM 04 work plan.

**c. Plan for the Coming Year**
A: Assure that all DFCHS funded programs interacting with women of childbearing age focus efforts on populations at greatest risk.

This infrastructure level strategy will be accomplished by: 1) evaluating smoking rates among black women in WIC and CFHS programs by reviewing data from the Perinatal Smoking Cessation Program; 2) redoing the Perinatal Periods of Risk analysis using the most recent data available; 3) supporting and including the work of the Ohio Collaborative to Prevent Infant Mortality, and the Action Learning Collaborative Addressing Infant Mortality and Racism; and 4) sharing the results of the Community Health Access Project (CHAP) evaluation with DFCHS programs and explore follow-up analysis in other population groups.

B: Continue to refine RFP language and provide technical assistance to DFCHS funded programs and Medicaid providers to ensure the appropriate target population is served.

This infrastructure level strategy will be accomplished by: 1) providing education to providers to conduct outreach to black women at high-risk of delivering a low birth weight baby; and 2) working with the SPM 04 Workgroup (see SPM 04).

**State Performance Measure 3:** *Percent of local health departments that provide health education and/or services in schools.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 45 |
| Annual Indicator | | 29.1 | 29.1 | 46.4 | 70.4 |
| Numerator | | 39 | 39 | 58 | 88 |
| Denominator | | 134 | 134 | 125 | 125 |
| Data Source | | LDH Grantee Reports | LDH Grantee Reports | LDH Grantee Reports | LHD Grantee Reports and Statewide Survey of LHD Se |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 45 | 45 | 45 | 45 | 45 |

**Notes - 2011**
The Provisional data has been derived from initial analysis of the Statewide Survey of LHD Services in Schools. The 2011 final report will provide additional detail on services delivered through contracts, Memorandum of Understanding or in-kind services.

**Notes - 2010**
Provisional data for FFY 2012 - New Objective which will require additional survey of internal programs and LHDs.Local Health Departments are funded from a variety of sources to work with

schools.

The data reflects a 17% increase in the number of local health departments providing services to schools. Data is derived from local health department grantee reports, specifically those funded to work directly in schools.
The Annual Indicator, number of health services, has decreased due to changes in funding and changes in state mandates. The Numerator, number of health departments who provide services, increased by 17%. This is reflective of the emphasis to reduce childhood obesity through school-based interventions. The Denominator, total number of health departments, decreased due to mergers and closings.

**Notes - 2009**
Provisional data entered based on this is a New Objective which will require additional survey of internal programs and LHDs.Local Health Departments are funded from a variety of sources to work with schools.

**a. Last Year's Accomplishments**
Percent of local health departments that provide health education and/or services in schools.

Goal: Increase the number of local health departments who contract with schools to provide health education, screenings and/or services in schools.
Strategies & Activities
• Collect baseline data about Local Health Departments currently working with schools
o A survey to capture the baseline number of contracts per service between local health departments and schools has been drafted. The survey will also capture technical assistance needs per topic area. The survey will be piloted with a small sample of local health departments in December 2011. The launch is scheduled for late January 2012.

• Create workforce development plan to assist Local Health Departments in working with schools
o Quarterly meetings were conducted with the ODH grant managers that oversee funds that are dispersed to local health departments to support school health services. This represents 22 program managers. The meetings provided opportunities to identify and assess gaps in services, identify topics for professional development, identify opportunities to collaborate, and identify best practices to enhance the local health department work in schools.

o A survey was conducted of the 22 Ohio Department of Health grant managers that support work in schools to identify professional development needs. Survey results identified the following needs:
-Improve communication strategies with schools
-Greater understanding of how schools operate
-Identifying existing school health policies and passing improved policies

o The School and Adolescent Health Section is working with Child and Family Health Services staff to support training for local health departments, funded by CFHS, on nutrition and physical activity for afterschool settings. Planning meetings occurred throughout the fall with the initial training to take place late winter 2012.

o 92 local health department nurses received medication training as part of the roll out across the state. The training occurred as a result of state legislation mandating all non-clinical staff dispensing medication be trained by a licensed medical person.

o Local health departments were provided technical assistance on their role in developing School Based Health Centers via weekly the Local Health Department conference calls. Dr. Marilyn Crumpton, the Executive Director of Growing Well Cincinnati, a premier school-based health care center, spoke of the need for local health department support and their role.

o The School and Adolescent Health section co-sponsored a training in August on Health Education Standards with the Buckeye Healthy School Alliance for state and local health department staff. Ohio is one of two states without Standards. The Buckeye Healthy School Alliance is working to pass legislation for state health education standards. Local health departments are increasing awareness of the need for standards.

-Promote Local Health Department services to school districts through school boards and administrators
o Information on how to correctly conduct a BMI screening has been placed on the Ohio Department of Education's website as a result of the passage of the Healthy Choices for Healthy Children Act. This Act requires school districts to conduct BMI screenings at grade level intervals or request a waiver. School administrators and board members can obtain accurate information on BMI screening from the state health and education department websites, as well as, receive technical assistance and training from state and local health department staff.

o Physical activity model policy was written in conjunction with the Ohio Department of Health and the Ohio Educational Service Center Association. The model policy was promoted at the state OESCA conference in October, 2011 that is attended by school administrators and school board members.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Collect baseline data about Local Health Departments currently working with schools | | | | X |
| 2. Create workforce development plan to assist Local Health Departments in working with schools | | | | X |
| 3. Promote Local Health Department services to school districts through school boards and administrators | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Percent of local health departments that provide health education and/or services in schools.

No changes to the strategies

**c. Plan for the Coming Year**
Percent of local health departments that provide health education and/or services in schools.

Completed: Strategy A: Collect baseline data about LHD's currently working in schools
Activities:
• Collaborate with other ODH program areas in development of LHD survey
• Determine and report types of formal relationships already in place between schools and LHDs
• Determine and report the services LHDs currently provide to school districts

Completed: Strategy B: Conduct needs assessment of LHDs
Activities:
• Develop questions to determine level of knowledge of LHDs regarding models and best practices for LHD-school partnerships
• Develop questions to determine resources needed to enhance LHD and school partnerships

Strategy C: Create a workforce development plan to assist LHDs in working with schools
Activities:
• Develop workforce development committee to create training series
• Review LHD survey results and create training needs list
• Develop and provide training series through Ohio TRAIN

Strategy D: Promote LHD services to school districts through school boards and administrators
Activities:
• Identify region and state education conferences to promote services
• Host joint meetings between LHD and school administrators to create plans to support needs of both agencies

**State Performance Measure 4:** *Degree to which DFCHS programs can incorporate and evaluate culturally appropriate activities and interventions.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 5 |
| Annual Indicator | | | | 5 | 5 |
| Numerator | | | | 5 | 5 |
| Denominator | | | | 5 | 5 |
| Data Source | | | | DFCHS Progra | DFCHS Progra |
| Is the Data Provisional or Final? | | | | | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 5 | 5 | 5 | 5 | 5 |

**Notes - 2011**
Provisional 2011 Data for the FFY2013 BG Report will be entered based on the Final 2010 Data.

The FFY12 Target was to complete 4 of 5 steps: : 1) Programs describe the racial/ethnic/cultural makeup of MCH populations served (on-going); 2) Programs describe culturally appropriate activities they are undertaking to address racial/ ethnic/cultural disparities; ; 3) Assess existing tools used for cultural competence; 4) Assess existing and needed partnerships. In collaboration with the ODH Public Health Data/Research Policy Advisory Committee (ODHDRPAC), completed an ODH Race and Ethnicity Data Standards document and 5) Create a Cultural and Linguistic Fidelity Toolkit.
Steps 1 is complete and on-going. Steps 2 and 3 are complete 4 is on-going and partially complete; the agency race/ethnicity standards are have been signed off by the assistant director to go to the Director; Step 5 has been delayed due to late receipt of HRSA TA funds. As a result, related processes and activities were delayed and timelines were adjusted. Other related critical activities completed: new survey tool was developed to capture and enhance needed data about the profile of populations served by DFCHS programs. The workgroup membership was intentionally expanded to include a more diverse racial & ethnic representation of Ohio's MCH

population  which now includes representation from state, local and community organizations.  An MCHBG TA Request was submitted to HRSA and approved, as Statement of Work was develop, distributed  and expert assistance via contractors was retained. Communication with the National Center for Cultural Competence (NCCC) continued.  NCCC conducted a live video conference for the SPM04 workgroup.

**Notes - 2010**
Due to late receipt of HRSA TA funds and related issues, work on SPM04 strategies, activities and related timelines had to be adjusted.  Work on  the Fidelity Toolkit, training of DFCHS staff, and development of the Train-the-Trainer Program Manual will be completed in multiple phases, after assessment of DFCHS staff, analyses of the survey results and completion of the strategic plan.

**Notes - 2009**
Provisional Data for 2009 based on Final 2008 Data

**a. Last Year's Accomplishments**
State Performance Measure 04:  Degree to which Division of Family and Community Health Services programs can incorporate culturally appropriate activities and interventions.

A. Develop and enhance a division-wide profile of populations served by DFCHS programs.

Accomplishment and/or Work is in progress:
• A survey tool was developed to capture and enhance needed updated information about the profile of populations served by DFCHS programs.  The tool has been piloted and is ready for distribution.

• Collaborated with the ODH Public Health Data/Research Policy Advisory Committee to develop ODH standards on tabulating racial and ethnic data for the purpose of improving the reporting of data in a consistent manner across programs. Standards have gone to the Associate Director of Health for approval and needs Director Approval to move forward with implementation.

B. Development of an Ohio Title V program plan that maps out a process to assist state-level Title V program staff and local grantees in moving along the continuum to cultural and linguistic competency. The plan should include guidance and/or tools for incorporating cultural/linguistic competence into each of the MCH BG national and state performance measures, as appropriate and for monitoring progress at both the state and grantee levels.

Accomplishment and/or Work is in progress:
• External participation on the workgroup was intentionally expanded by ten members to include a more diverse racial & ethnic representation of Ohio's MCH population which includes representation from state, local and community organizations.

• An MCHBG TA Request was submitted to HRSA and approved.  The goal was to obtain expert assistance in the development of a tool to assess the cultural and linguistic competence and training needs of the ODH MCH DFCHS staff. A project Statement of Work (SOW) was developed and distributed to prospective consultants.  Responding consultants were interviewed based on results, a firm was retained.

• Communication with the National Center Cultural and Linguistic Competence (NCCC) continued.  NCCC conducted a live video conference for SPM 04 workgroup members on August 18, 2011.  The topic was ‘Conducting Cultural and Linguistic Competence Organizational Assessment.

• Due to the late receipt of HRSA TA funds and related issues, work on SPM04 strategies and timeline have had to be adjusted.  Work on the Fidelity Toolkit, training of DFCHS staff, development of the Train-the-Trainer Program Manual will be completed in multiple phases, after the assessment of DFCHS staff and analyses of the results and completion of the strategic plan.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Develop and enhance a division-wide profile of populations served by DFCHS programs. | | | | X |
| 2. Development of an Ohio Title V program plan that maps out a process to assist state-level Title V program staff and local grantees in moving along the continuum to cultural and linguistic competency. | | | | X |
| 3. Communication with the National Center Cultural and Linguistic Competence (NCCC) continued. | | | | X |
| 4. Collaborated with the ODH Public Health Data/Research Policy Advisory Committee to develop ODH standards on tabulating racial and ethnic data for the purpose of improving the reporting of data in a consistent manner across programs. | | | | X |
| 5. | | | | |
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**b. Current Activities**

Strategy A: Develop and enhance a division-wide profile of populations served by DFCHS programs

1.Develop and enhance a division-wide profile of populations served by DFCHS programs.

2.Collaborate with the ODH Public Health Data/Research Policy Advisory Committee to develop ODH standards or tabulating racial and ethnic data for the purpose of improving the reporting of data in a consistent manner across programs.

a.Standards have gone to the Associate Director for approval and needs Director Approval to move forward with implementation. On Director's approval plans can proceed to develop a standard data model for training developed for ODH and then Train DFCHS staff on ODH data standards for the purpose of improving collection of data on race and ethnicity across programs.

Strategy B:. Incorporate selected culturally appropriate activities and interventions into State DFCHS programs.

1. Due to the late receipt of HRSA TA funds and related issues, work on SPM04 strategies and related timelines had to be adjusted. Work on the Fidelity Toolkit, training of DFCHS staff, development of the Train-the-Trainer Program Manual will be completed in multiple phases, after the assessment of DFCHS staff and analyses of the results and completion of the strategic plan.

2. A survey tool has been created to assess staff of the DFCHS programs to learn about cultural and linguistic training needs. The tool is in its final development stage and will be disseminated soon.

**c. Plan for the Coming Year**
Performance Measure 04: Degree to which State DFCHS programs can incorporate culturally appropriate activities and interventions

Strategy A: Develop and enhance a division-wide profile of populations served by DFCHS programs
1. Develop and enhance a division-wide profile of populations served by DFCHS programs. This is an infrastructure building activity. This objective will be measured through the completion of the division profile. Profile will be updated of populations served by programs

2. Collaborate with the ODH Public Health Data/Research Policy Advisory Committee to develop ODH standards or tabulating racial and ethnic data for the purpose of improving the reporting of data in a consistent manner across programs. This is an infrastructure activity. Collaborate with ODHDRPAC to develop race and ethnicity data standards for the purpose of improving the collection, reporting and tabulation of data on race and ethnicity across ODH programs. Guidelines report will be shared as an official DFCHS guide and the recommendations implemented. Use of race and data standards approved by senior ODH management and standards implemented across ODH. Standard data model for training developed for ODH and then Train DFCHS staff on ODH data standards for the purpose of improving collection of data on race and ethnicity across programs.

Strategy will be measured through data standards approved and implemented agency-wide and standard training model developed and approved.

Strategy B: Incorporate selected culturally appropriate activities and interventions into State DFCHS programs
Utilize the results from the DFCHS Cultural and Linguistic Competence Survey Assessment analyses report, and with expert consultant assistance, the workgroup proposes to continue the work.
1. Develop a strategic plan mapping out a process for DFCHS state level Title V program staff and local grantees to move along the cultural and linguistic competency continuum.

2. Design a plan for marketing the "how-tos" for this movement.

3. Construct a Fidelity Tool-kit containing guidance and tools for implementing, monitoring, and evaluating cultural and linguistic competency.

4. Provide cultural and linguistic competency training to DFCHS staff, based on plan developed in the FFY 2013 Strategic Plan developed to assist state-level Title V staff and local grantees in moving along the continuum to cultural and linguistic competency.

a. Outline initiatives, activities and proposals in collaboration with the MCH programs and in collaboration with HR Workforce development and Healthy Ohio Health Equity coordinator to develop as tools and guidance are being developed.

b. Implement DFCHS cultural and linguistic competency training, including a multi-day Culture College event (unique educational experience in which participants are immersed in the values, icons, traditions and practices of a specific culture and/or different cultures).

## State Performance Measure 5: *Percent of 3rd Graders Who are Overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| **and Performance Data** | | | | | |
| Annual Performance Objective | | | | | 36.5 |
| Annual Indicator | | 35.9 | 36.5 | 34.7 | 35.6 |
| Numerator | | 45596 | 47958 | 45593 | 46775 |
| Denominator | | 126855 | 131392 | 131392 | 131392 |
| Data Source | | Ohio 3rd Grade BMI Survey | Ohio 3rd Grade BMI Survey | Ohio 3rd Grade BMI Survey, Oza-Frank R, Norton A. | Ohio 3rd Grade BMI Survey |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 36 | 35.5 | 34 | 34 | 34 |

**Notes - 2011**
Provisional 2011 data is based on final 2010 data.

**Notes - 2010**
Represents data from the 2009/2010 school-year

**Notes - 2009**
Represents data from the 2008/2009 school-year

In 2009-2010 Ohio had a lower proportion of overweight/obesity (34.7%(95%CI:32.9-36.5)and a lower proportion of obesity(18.3%(95% CI: 16.6-20.2)) Source is 2009/10 county level BMI surveillance survey

**a. Last Year's Accomplishments**
A. Conduct data surveillance and monitoring activities
• ARRA funded Body Mass Index (BMI) projects were awarded to local health districts (LHD) across the state in an effort to increase BMI surveillance activities at the local level. This federal grant enabled ODH School and Adolescent health to provide a medical grade scale, stadiometer and BMI training to approximately 50% of the counties in the state. LHD were matched with after school programs and were asked to conduct BMI surveillance as part of the Physical activity and nutrition plan. The surveillance results were then submitted to ODH and are currently being analyzed.
• The implementation of a new state law SB210 Healthy Choices for Healthy Children legislation in the last year required schools to conduct BMI screenings or actively request a waiver not to participate. The participating school districts were required to conduct BMI screenings on the students in the following grades: Kindergarten, 3rd, 5th and 9th. A final report indicated that 242 districts submitted aggregated student BMI screening data to the Ohio Department of Health in the 2010-2011 school year. This data is in the process of being analyzed.
• The sample was drawn for the 3rd Grade BMI Surveillance program to be conducted in the 2011-2012 school year. The school district Superintendents were contacted requesting permission for their school district to participate and the process of setting dates for the data collection began.

B. Increase health care provider's awareness and involvement in prevention and treatment initiative
• Continued promotion of Ounce of Prevention to health care providers. The Ounce of Prevention toolkit was created through collaboration between ODH, Nationwide Children's Hospital and National Dairy Council Mid-east in 2007, updated and expanded to include ages birth to 18 years in 2010, to address the growing epidemic of childhood obesity. This preventive approach was

designed to provide simple tools to educate parents about good nutrition and physical activity for their children. This toolkit includes evidence-based messages as recommended by the Expert Committee within the National Initiative for Children's Healthcare Quality (NICHQ) and the American Academy of Pediatrics.There was a presentation of Ounce of Prevention to the Minnesota Chapter of AAP, and the Mayo Clinic. Poster presentations were a part of the North Carolina AAP convention and Western New York AAP conference. Pediatrician offices and public health care clinics across Ohio continue to be trained on the use of Ounce of Prevention and continue with its implementation through the guidance of ODH and the continued collaboration with Nationwide Children's Hospital and Dairy Council.

C. Explore new opportunities for collaboration
• Internally ODH continues to work toward coordinating the efforts of all ODH personnel addressing the issue of childhood obesity. Staff has been collaborating across divisions to conduct trainings and workshops on evidence based program s to prevent and treat childhood obesity. In addition the staff continues to work together on educating school personnel and the general public on legislation to improve physical activity (PA) and school nutrition in Ohio.
• ODH staff continues to work with Ohio Action for Healthy Kids (OAFHK), through attendance at the meetings and by providing technical assistance to this state level initiative. ODH provides OAFHK with childhood obesity data and partners with the OAFHK leaders to conduct regional trainings. ODH MCH school staff continues to participate on a national level to assist AFHK in the implementation of their strategic plan.
• A new collaborative partnership was formed last year with the Ohio Afterschool Network (OAN). This partnership was formed to build evidence based programming for PA and nutrition in the afterschool programs. In addition staff has participated on writing teams to develop policies and recommendations for health and nutrition standards to be adopted statewide by the afterschool association. In 2011, ODH staff participated in the writing of the Ohio physical activity guidelines, Ohio Kids on the Move, for after school programs.
• The Buckeye Healthy School Alliance has ODH staff serving on each of its subcommittees. The subcommittees are working on a variety of goals based o

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Conduct data surveillance and monitoring activities | | | | X |
| 2. Increase health care provider's awareness and involvement in prevention and treatment initiatives. | | | X | |
| 3. Explore new opportunities for collaboration | | | | X |
| 4. Investigate evidence based intervention for school aged population. | | | | X |
| 5. Participate in the development of a statewide plan for addressing childhood obesity | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
State Performance Measure #5
Percentage of 3rd Graders Who Are Overweight

No changes to the strategies.

**c. Plan for the Coming Year**
State Performance Measure #5
Percentage of 3rd Graders Who Are Overweight

Goal: To decrease the rate of obesity in the school aged population

Strategies
A. Conduct data surveillance and monitoring activities.
1) Conduct 3rd grade BMI surveillance
2) Conduct BMI surveillance program in 30 school age child care programs across the state and analyze the data.
3) Analysis and reporting of the 2010-2011 Healthy Choices for Healthy Children Act BMI data

B. Increase health care providers awareness and involvement in prevention and treatment initiatives.
1) Continue to promote Ounce of Prevention Program to health care providers
2) Participate on the Ohio AAP Ounce of Prevention advisory committee
3) Work with Nationwide Children's Hospital on Survey questions for Physicians offices pertaining to the collection of BMI data.

C. Continue to explore opportunities for collaboration.
1) Collaborate with Buckeye Healthy School Alliance and the Ohio Department of Education (ODE) to promote and conduct the Coordinated School Health Conference in June 2012.
2) Continue with collaboration with the ODE to conduct trainings on the CATCH (Coordinated Approach to Child Health) program.
3) Collaborate with ODE and the Healthy Choices for Healthy Children Council on the development of resources for schools participating in BMI screening programs.
4) Collaborate with Nationwide Children's Hospital to expand the Ounce of Prevention program through the development of materials for use in the school and child care setting.

D. Investigate evidence based interventions for the school aged population related to nutrition and physical activity.
1) Work with the ODE Physical Education Department and the Coordinated School Health Team to promote evidence based PA programs in schools.
2) Work with Action for Healthy Kids to continue to promote the implementation and evaluation of the Catch Kids Club program in after school programs.
3) Work with Nationwide Children's Hospital on the evaluation of childhood obesity treatment programs currently being piloted in Ohio.

**State Performance Measure 6:** *Development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and evaluate preconception health efforts.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 1 |
| Annual Indicator | | | | 1 | 2 |
| Numerator | | | | 1 | 2 |
| Denominator | | | | 7 | 7 |
| Data Source | | | | TBD | Not Yet Det |
| Is the Data Provisional or Final? | | | | | Provisional |

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3 | 5 | 6 | 7 | 7 |

**Notes - 2011**
NOTE: Ohio deleted the Data Source information that was in these cells because it is not accurate. There are and will never be data sources for this measure because we are using benchmarks listed on the Detail Sheets. The benchmark numerators and denominators are correct.

**Notes - 2010**
Workgroup is researching preconception health related indicators from which to select a final list of indicators. Potential sources for these indicators include the multi-state set of preconception indicators, a study of preconception health among Appalachian women, data from the Gestational Diabetes study, PRAMS, BRFSS and others. Following the selection of indicators, the group will identify gaps and move forward with assessing capacity to collect those data.

Data issues are not reported this is a new measure that was created for FFY2011.

The group reviewed available indicator lists, including: CDC Preconception Health and Healthcare Steering Committee Preconception Health Domains and Indicators; ODH Data Center Preconception Health Data Book; Gestational Diabetes Data Book; Preconception Health Indicators in Appalachia; PRAMS; BRFSS; Ohio Family Health Survey; Ohio Vital Statistics; Ohio’s 2011 State Health Needs Assessment Data Report; Maternal and Child Health Block Grant National and State Performance Measures; and Ohio Sexually Transmitted Diseases Database.

NOTE: I deleted the Data Source information that was in these cells because it is not accurate. There are and will never be data sources for this measure because we are using benchmarks listed on the Detail Sheets. The benchmark numerators and denominators are correct.

**a. Last Year's Accomplishments**
Development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and evaluate preconception health efforts.

During FY11, one benchmark (of seven) was completed: selecting a core set of preconception health indicators. Progress on activities for FY11 is noted below.

Identify and review available lists of women's health indicators developed by ODH and other entities (Infrastructure).

The group reviewed available indicator lists, including: CDC Preconception Health and Healthcare Steering Committee Preconception Health Domains and Indicators; ODH Data Center Preconception Health Data Book; Gestational Diabetes Data Book; Preconception Health Indicators in Appalachia; PRAMS, BRFSS; Ohio Family Health Survey; Ohio Vital Statistics; Ohio's 2011 State Health Needs Assessment Data Report; Maternal and Child Health Block Grant National and State Performance Measures; and Ohio Sexually Transmitted Diseases Database.

Following review of existing data sources and indicators, compile a proposed list of Preconception Health Indicators (Infrastructure).

In July, 2011, the group met with Dr. Bill Sappenfield, who was a member of the CDC Preconception Health and Healthcare Steering Committee that developed the national list of Preconception Health Domains and Indicators. He encouraged us to focus on what we hope the list of indicators will do for us and how it will help us accomplish our goals.
Following our meeting, the group decided to take a two-pronged approach developing a list of

preconception health indicators. On an annual basis, we will monitor the 37 indicators included in the ODH Data Center Preconception Health Data Book. This will provide a picture of what is happening in Ohio, which may help in creating political will to target specific issues over time. This list of indicators will also allow us to compare Ohio rates with other states and the nation. From this list, we will select a smaller number of indicators on which to concentrate our efforts. This will allow us to target areas where we can have the greatest impact and use the measures as a way to track success.

From the final list of recommended Preconception Health Indicators, identify gaps in availability of data (Infrastructure).

This goal was not completed during FY11 because the group chose to establish our list of preconception health indicators from already existing data. Therefore we will not be attempting to identify ways to collect data that are not currently available.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Identify and review available lists of women's health indicators developed by ODH and other entities | | | | X |
| 2. Following review of existing data sources and indicators, compile a proposed list of Preconception Health Indicators | | | | X |
| 3. From the final list of recommended Preconception Health Indicators, identify gaps in availability of data | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

A. Following review of existing data sources and indicators, compile a proposed list of Preconception Health Indicators (Infrastructure).

The workgroup is actively working on this strategy.

B. From the final list of recommended Preconception Health Indicators, identify gaps in availability of data (Infrastructure).

This strategy has been revised to limit the list of indicators to those with already available data. The decision was made to focus on making an impact on these indicators vs. investing time and energy on development new data collection systems. The workgroup is actively working on this strategy.

C. Identify methods to increase data capacity to implement and sustain data collection, linking and analysis activities (Infrastructure).

This strategy has been revised. Though we will look for opportunities to link data sets, we have decided work with already available data and tailor our list to reflect current priorities of Ohio Department of Health programs. The workgroup is actively working on this strategy.

**c. Plan for the Coming Year**
Development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and evaluate preconception health efforts.

A. Identify methods to increase data capacity to implement and sustain data collection, linking and analysis activities (Infrastructure). This will include addressing gaps in resources for data collection and potential for overcoming those gaps.
1. Investigate additional data sources for selected indicators to enhance understanding of preconception health.
2. Identify gaps in data collection and data quality issues as opportunities to improve Ohio's set of preconception health indicators.

B. Increase capacity to evaluate preconception health efforts by on-going monitoring of indicator data (Infrastructure).
1. Evaluate current use of preconception health indicators in program and policy decision making process.
2. Provide preconception health indicator data to program staff to reinforce the "data to action" message.
3. Explore opportunities to share preconception health data via the ODH Data Warehouse with internal and external partners

C. Coordinate SPM 06 activities with recommendations addressed by the Ohio Collaborative to Prevent Infant Mortality (OCPIM) (Infrastructure).
1. Identify methods to coordinate SPM 06 work group activities with Data Committee of OCPIM.

## State Performance Measure 7: *Percentage of third grade children with untreated caries*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 20 |
| Annual Indicator | | 23.0 | 23.2 | 18.7 | 18.7 |
| Numerator | | 29814 | 29457 | 24545 | 24545 |
| Denominator | | 129671 | 127099 | 131392 | 131392 |
| Data Source | | Ohio OpenMouth Oral Health Survey | Ohio OpenMouth Oral Health Survey | Ohio OpenMouth Oral Health Survey | Ohio OpenMouth Oral Health Survey |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance | 18 | 18 | 18 | 18 | 18 |

| | | | | | |
|---|---|---|---|---|---|
| Objective | | | | | |

**Notes - 2011**
Ohio uses a statewide open-mouth oral health survey (using the Basic Screening Survey model) to estimate this measure. About every five years (2009-10 was the most recent) the survey is completed at the county level. The next survey will be conducted from 2013-2015.

*New data available in 2015.

**Notes - 2010**
This is a significant decrease from previous surveys (25.7% in previous county-level survey in 2004-05, and 23.2 in previous state-level survey in 2008-09). While untreated decay has decreased for Ohio third graders in general, disparities still exist. Over 27% of third graders in Appalachia and 26% of low income children across the state had untreated decay in 2009-10.

Ohio uses a statewide open-mouth oral health survey (using the Basic Screening Survey model) to estimate this measure. About every five years (2009-10 was the most recent) the survey is completed at the county level. The next survey will be conducted from 2013-2015.

**Notes - 2009**
Final 2009 Data from the 2008/2009 Sentinel School Survey

**a. Last Year's Accomplishments**
A. Encourage and enable Ohio communities to prevent dental caries through community-based fluoride promotion.
The Oral Health Section (OHS) updated community water systems fluoridation data on the ODH Web and the CDCP Water Fluoridation Reporting System.

Technical assistance was provided to- villages/cities regarding community water fluoridation; schools in the Fluoride Mouthrinse Program; physicians in the state Fluoride Varnish Program; and, colleagues in the Division of Drinking and Ground Water/Ohio Environmental Protection Agency.

OHS reviewed fluoride monthly operating reports from water systems that adjust fluoride content. One hundred seventy-six systems (83 percent) received a Quality Award for consistent adjustment of the water fluoride content during 2010.

Six community water systems that serve 197,465 Ohioans received reimbursement through the OHS's Fluoridation Reimbursement Program. A total of $21,239.00 was disbursed.

B. Strengthen and support the dental care safety net.
OHS funded 20 sub-grants to safety net dental clinics. The safety nets provided dental care to 69,239 unduplicated patients. Quality assessment/improvement methodology for this program was developed/piloted in 2011.

OHS collaborated with private foundations for the "Strengthen Ohio's Safety Net" initiative to improve health care access for underserved populations and enhanced the distribution/diversity of the healthcare workforce through presentations/discussion related to strategy formulation/prioritization.

Online tools/information to start/maintain safety net dental clinics in Ohio, www.ohiodentalclinics.com, was developed by the ODH and the National Maternal and Child Health Oral Health Resource Center (NMCHOHRC) at Georgetown University. The NMCHOHRC hosts/maintains the Website which includes online trainings with free dental continuing education for dental safety net professionals and school-based sealant programs. NMCHOHRC posts messages via e-mail /Twitter with information pertinent to safety net dental clinics with a link to the user.

OHS collaborates with the Association of State and Territorial Dental Directors, the Indian Health Service, the National Network for Oral Health Access, the NMCHOHRC and Safety Net Solutions to maintain/improve the online Safety Net Dental Clinic Manual (www.dentalclinicmanual.com).

Ohio Dentist Loan Repayment Program funded 6 dentists for loan repayment in 2011. A new loan repayment program developed in 2010 through a HRSA Workforce grant contracted with six dentists in the spring of 2011. Dentists in both programs provided dental care to 8,981 unduplicated patients.

OHS submitted 4 new/22 renewal applications for federal dental health professional shortage area (HPSA) designations to HRSA. There are currently 71 dental HPSA designations in Ohio.

C. Make data and other information available to help communities and policy-makers.
County-level oral health data were updated in the Ohio Oral Health Surveillance System.
A report on the oral health of Ohioans (with data from the 2009-10 statewide oral health survey of schoolchildren) was written/printed and then distributed in August 2011.
A sentinel oral health screening survey of Ohio third graders was conducted in 30 schools during the 2010-11 school year. A total of 1,138 students were screened; data analysis was completed and trend data was made available. *The sentinel survey will be discontinued after the 2010-11 school year; only the large scale statewide oral health screening survey will be conducted every 5 years. The yearly sentinel survey data over the past 10 years has confirmed the validity of the larger statewide survey data so there is no longer the need to conduct it.
OHS Website provides information on oral health topics/data/resources for dental and other health professionals; OHS programs/funding opportunities and oral health policy issues.
OHS staff provided presentations to dental and dental hygiene students, provided sub-grantees assistance on reporting, conducted site visits and provided in-services for the school-based fluoride mouthrinse program.
The Oral Health Section Administrator is a member of the Children's Oral Health Action Team and participated in quarterly and workgroup meetings.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Encourage and enable Ohio communities to prevent dental caries through community-based fluoride promotion. | | | | X |
| 2. Strengthen and support the dental care safety net. | | | | X |
| 3. Make data and other information available to help communities and policy-makers. | | | | X |
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**b. Current Activities**
Percentage of 3rd grade children with untreated caries

No strategies have changes.

**c. Plan for the Coming Year**
Percentage of 3rd grade children with untreated caries

Related Healthy People 2020 oral health objective 21.2: Reduce the proportion of children, adolescents and adults with untreated dental decay.

Strategy A: Encourage and enable Ohio communities to prevent dental caries through community-based fluoride promotion.
1. Maintain fluoridation and related information on the BCHS Website;
2. Maximize the impact of Ohio's fluoridation statue through fluoridation promotion and education efforts;
3. Collaborate with Ohio EPA to evaluate fluoridation quality and monitor the state fluoridation census.
4. Provide the opportunity for communities without optimal water fluoridation to operate school-based fluoride mouth rinse (FMR) programs

Strategy B: Strengthen and support the dental care safety net.
1. Fund subgrants for the support to safety net dental clinics.
2. Monitor quality and improvement of the Safety Net dental care subgrants utilizing the Oral Health Program's quality assessment and improvement methodology.
3. Provide technical assistance to agencies interested in operating safety net dental clinics.
4. Continue to collaborate with the National Maternal and Child Oral Health Resource Center on development of distance learning modules for the Ohio Safety Net Dental Clinic Website.
5. Collaborate with Safety Net Solutions, the Association of State and Territorial Dental Directors, the Indian Health Service, the National Maternal and Child Oral Health Resource Center to maintain and improve the safety net dental clinic manual (www.dentalclinicmanual.com).
6. Administer the Ohio Dentist Loan Repayment Program.
7. Prepare and submit renewal and new applications for federal Dental Health Professional Shortage Area (HPSA) designations in Ohio.
8. Collaborate with Ohio Foundations on the Oral Health Capacity Building Project.
9. Administer Dental OPTIONS in collaboration with the ODA.

## State Performance Measure 8: *Reduce deaths of adolescents (age 10-19) due to intentional and unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 0 |
| Annual Indicator | | | 1.5 | 2.3 | 2.3 |
| Numerator | | | 234 | 193 | 193 |
| Denominator | | | 1563347 | 823682 | 823682 |
| Data Source | | | Vital Statistics/US Census | Vital Statistics/US Census | Vital Statistics/US Census |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Annual Performance Objective | 2 | 2 | 0 | 0 | 0 |

**Notes - 2011**
FY2011 data is provisional based on the FY2010 final data.

**Notes - 2010**
Self-report data from adolescents are collected in the YRBS. Data about cause of death are available from Vital Statistics and CFR. Data regarding motor vehicle accidents are available from ODOT, NHTSA, ODPS. Data about mental health and substance abuse are available from National Household Survey on Drug Abuse (NHSDA), SAMSHA, ODADAS. The Census provides number of Ohio adolescents in this age group.

Self-report data from adolescents are collected in the YRBS. Data about cause of death are available from Vital Statistics. Data regarding motor vehicle accidents are available from ODOT, NHTSA, and ODPS. The Census provides number of Ohio adolescents in this age group.

Accuracy of Suicide Data is some what difficult to obtain as some deaths described as unintentional may have been committed as a result of a suicide action .i.e. car crashes and poisonings could be actions used to intentionally harm oneself

**Notes - 2009**
Numerator: 2009 Vital Statistics final death file (cause of death=motor vehicle accident, poisoning, and suicide)

Denominator: US Census Bureau 2009 population estimates

**a. Last Year's Accomplishments**
State Performance Measure 8: Reduce deaths of adolescents (age 10-19) due to intentional and unintentional injuries.

Goal: To reduce the number of deaths among Ohio adolescents (age 10-19) due to motor vehicle accidents, poisoning and suicide.

A. Create Adolescent Health Council to gather stakeholders to address prevention of adolescent deaths due to intentional and unintentional injuries.
Ohio successfully obtained weighted data for the Youth Risk Behavior Survey in 2011. The summary of the data from CDC was submitted to Ohio in September 2011. Data was presented to the ODH Adolescent Health Council to inform the work of the council when prioritizing health issues to address within Ohio's adolescent health strategic plan. Members for the Adolescent Health Council were recruited from across the state and two meetings were held in November and May. Adolescent health care professionals representing each of the 5 Children Hospitals, the Ohio AAP and the Society for Adolescent Medicine as well as state agencies (Mental Health, Education and Drug and Alcohol) county and local social service organizations attended the committee meetings. Strategic planning activities resulted in a prioritization of the top 5 health issues for Ohio's adolescents. The following health issues identified are: Nutrition/Physical Activity/Sleep, Reproductive Health, Mental Health, Violence/Injury Prevention, and Substance Abuse. Each issue has an assigned work group that will develop strategies for each of the health issues. Effective 12/2011 Workgroups will be meeting quarterly to develop plans and identify champions for implementation. Data for each of the topics were reviewed to inform prioritization process. Child Fatality Review Data was presented as well as Ohio's 2011 YRBS and vital stats data.

B. Reduce the number of adolescent deaths due to motor vehicle accidents
Data from the 2011 Ohio Youth Risk Behavior Survey supports that Ohio's teens are practicing

safe driving habits such as wearing safety belts and refraining from drinking and driving. Since 1993 Ohio has had a significant increase in the number of youth who wear a seatbelt when riding in a car with Eighty three % of Ohio's teens report wearing a seat belt in 2011. Drinking and driving was also significantly reduced with 92% of Ohio's teens report NOT drinking in driving a vehicle. Further support to decrease teen deaths from motor vehicle accidents has been through activities related to the work of the National Safety Council. Members of Ohio's Adolescent Health program attended the kick off meeting of the Teen Safe Driving Coalition in Ohio. The Safe Driving Coalition formed in May 2011, is already hard at work on strategies to address the state's culture of teen safe driving using the principles of Graduated Driver Licensing (GDL). The coalition, made possible through a grant from the Centers for Disease Control and Prevention, has a four-pronged plan: Strengthening GDL through legislation; Engage teens and give them tools to talk to one another; Increase parental involvement through education; Educate Ohio citizens through media. The adolescent health advisory committee will support these efforts by focusing on education and dissemination of information to parents and communities. Council members agreed to assist the efforts by l distributing information on the GDL in their offices as part of the anticipatory health guidance done during adolescent's annual exams and at other times when families are obtaining services for their teens from local providers.

C. Reduce the number of adolescent deaths due to poisoning
Prescription Drug Abuse has become an increasing problem in Ohio. Two new questions were added to the 2011 Ohio YRBS to identify the types of prescription drugs most used/abused by teens. The Data from the 2011 Ohio Youth Risk Behavior Survey revealed that Ohio's teens are actively using prescription drugs for recreational purposes putting them at risk of injury and death. Data indicates that 21.3% have used prescription pain relievers in their lifetime and 3.1% have used heroin. Narcotic pain relievers were most often used by 12% of teens who abuse prescription drugs however approximately 4% responded that they don't know the type of prescription drugs they are taking. The data was presented at the annual Ohio Prevention Education Conference (OPEC) to inform drug and alcohol coalitions acro

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Create Adolescent Health Council to gather stakeholders to address prevention of adolescent deaths due to intentional and unintentional injuries. | | | | X |
| 2. Reduce the number of adolescent deaths due to motor vehicle accidents | | | | X |
| 3. Reduce the number of adolescent deaths due to poisoning | | | | X |
| 4. Reduce the number of adolescent deaths due to suicide | | | | X |
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**b. Current Activities**
State Performance Measure 8: Reduce deaths of adolescents (age 10-19) due to intentional and unintentional injuries.

No change to strategies.

**c. Plan for the Coming Year**
State Performance Measure 8: Reduce deaths of adolescents (age 10-19) due to intentional and unintentional injuries.

• Create Adolescent Health Council to gather stakeholders to address prevention of adolescent deaths due to intentional and unintentional injuries.
o The following stakeholders have been convened to address injury (intentional and unintentional)to include (but not limited to): CFR, Injury Prevention
o External stakeholders include (but not limited to): Public Safety, ODADAS, Mental Health, Poison Control, NCTSN, ODE
o Council will gather data and create and/or update 21 Indicator report of baseline incidence of selected deaths
o Council will review and create report on current prevention efforts directed at these causes of death
o Council will identify gaps in programming that can be addressed by evidence based programs to prevent these deaths

• Reduce the number of adolescent deaths due to motor vehicle accidents
o Analyze crash data from ODPS, including deaths to pedestrians, drivers and passengers associated with motor vehicles
o Review teen driving interventions for effectiveness
o Review teen driving interventions for cultural diversity/appropriateness
o Review current activities to increase use of bicycle helmets, motorcycle helmets, safety belts, drinking & driving and other prevention programs; determine if current activities are successful or should be revised
o Work with OIPP teen driving sub committee on developing recommendations and supporting activities and programs to prevent deaths due to motor vehicle accidents

• Reduce the number of adolescent deaths due to poisoning
o Analyze data about adolescent deaths due to poisoning, including data about substance abuse/accidental overdose of both illicit and prescription drugs
o Review poisoning/substance abuse interventions for effectiveness
o Review current activities to decrease poisoning/substance abuse; determine if current activities are successful or should be revised
o Recommend and implement activities and programs to prevent deaths due to poisoning/substance abuse

• Reduce the number of adolescent deaths due to suicide
o Analyze data about adolescent deaths due to suicide, including data about mental health and substance abuse co morbidities and access to firearms
o Review suicide prevention interventions for effectiveness
o Review suicide prevention interventions for cultural diversity/appropriateness
o Review current activities to decrease suicide; determine if current activities are successful or should be revised
o Partner with ODE, ODMH, NAMI to support recommendations and programs to prevent deaths due to suicide

**State Performance Measure 9:** *Maintain/enhance the Ohio Connections for Children with Special Needs (OCCSN) birth defects information system to improve use of data for surveillance, referrals to services and prevention activities.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|

| Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 2 |
| Annual Indicator | | | | 2 | 2 |
| Numerator | | | | 2 | 2 |
| Denominator | | | | 6 | 6 |
| Data Source | | | | OCCSN System | OCCSN System |
| Is the Data Provisional or Final? | | | | | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 3 | 4 | 6 | 6 | 6 |

**Notes - 2011**
Prevalence rates completed for spina bifida and oral facial clefts.

**Notes - 2010**
Data from OCCSN system; referral outcome data from Early Track system and CMACS system; and prevention activity data from Ohio Partners for Birth Defects Prevention meetings.

While Ohio has implemented statewide reporting of children with birth defects, improvements in epidemiology capacity and IT enhancements will allow for increased utilization of birth defects data for prevalence and trend analyses, referrals to services and prevention activities.

Benchmarks:
1. Complete prevalence rate analyses for spina bifida, oral/facial clefts, trisomies 13, 18, 21
2. Submit birth defects data to CDC
3. Implement referral to services protocol statewide for specific diagnoses
4. Complete 4 IT enhancements within OCCSN system for flagging birth address, program report option to facilitate research analyses, change search screen, automate process to identify and fix duplicate records
5. Complete and distribute OCCSN annual report
6. Demonstrate utilization of data in planning and implementing prevention activities.

FFY2011 Additional Annual Report Information:

(4) IT enhancements were made to OCCSN during FFY11 as listed in Benchmark #4. Additional IT enhancements are underway and a major IT enhancement is planned for implementation in Nov. 2011.
Data from PRAMS and spina bifida prevalence rates from OCCSN have been used to develop prevention activities.

Prevalence rates for spina bifida and oral/facial clefts completed in FFY2011. Prevalence rates for the trisomies will be completed by Nov. 2011.

**a. Last Year's Accomplishments**
Maintain/enhance the Ohio Connections for children with Special Needs (OCCSN) birth defects information system to improve the utilization of data for surveillance, referrals to services and prevention activities.

Benchmark 1: Complete prevalence rate analyses for spina bifida, oral/facial clefts, and trisomies 13, 18, 21
Activities:
1. By 9/30/2011, the OCCSN Coordinator and OCCSN Epidemiologist will complete prevalence rates and associated analyses for the 2008 birth cohort for spina bifida, oral/facial clefts and trisomy 13, trisomy 18 and trisomy 21 and disseminate results.

REPORT OF ACCOMPLISHMENTS: Prevalence rates for spina bifida and oral facial clefts are complete. Prevalence rates for trisomies are underway but not yet complete. Data issues backed up the timeline for completion.
• Prevalence rate for spina bifida in Ohio for 2008 birth cohort = 3.0/10,000 live births. National average for state birth defects surveillance systems using passive case ascertainment with follow-up = 2.7/10,000 live births.
• Prevalence rates for oral facial clefts in Ohio for 2008 birth cohort:
o Cleft lip with or without cleft palate = 9.6/10,000 live births
o Cleft lip only = 4.2/10,000 live births
o Cleft palate without cleft lip = 7.7/10,000 live births

Benchmark 3: Implement the referral to services protocol statewide for specific diagnoses.
Activities:
2. By the end of 9/30/2011, The OCCSN Coordinator will make referrals to Help Me Grow for children <= 2 years of age with spina bifida, oral/facial clefts and trisomies 13, 18, 21.
3. IT enhancements to the OCCSN system will automate referrals to HMG.
4. OCCSN staff will work with ODH HMG staff to review outcomes of referrals in Early Track.

REPORT OF ACCOMPLISHMENTS: Referrals were made to the Help Me Grow system. Most children with trisomies were found to already be linked with early intervention services. IT enhancements to automate referrals is not complete. Lack of IT time dedicated to OCCSN delays completion of some IT projects. OCCSN staff meet regularly with Help Me Grow staff to discuss improvements to the referrals to services and outcome measure for children with birth defects. This is an ongoing activity.

Benchmark 4: Complete IT enhancements within OCCSN
Activities:
5. OMIS staff will develop marker for noting address at birth in system
6. OMIS staff will develop improved de-duplication routine to improving matching with vital records and merging multiple records for the same child

REPORT OF ACCOMPLISHMENTS: The birth address is flagged in the OCCSN system to facilitate determining state residents vs. out of state residents, and a de-duplication routine was developed for the OCCSN Coordinator to merge records of the same child. A large IT enhancement project is underway and scheduled for completion in March, 2012. This project will automatically upload hospital birth defects reports that meet the specifications of the OCCSN system directly into OCCSN and provide immediate feedback to hospitals whose records are not able to be uploaded so they can revise and re-submit. This will improve the timeliness of when the records are available for referrals and statistical analysis. This will also improve the quality of the data by not allowing data that is incomplete or that does not meet the specifications of OCCSN to be uploaded into the system.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Complete prevalence rate analyses for spina bifida, oral/facial clefts, and trisomies 13, 18, 21. | | | | X |
| 2. Implement the referral to services protocol statewide for specific diagnoses. | | | | X |
| 3. Complete IT enhancements within OCCSN | | | | X |
| 4. | | | | |
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**b. Current Activities**

• Added a new activity #2 that includes IT enhancements currently underway for the OCCSN system that will improve timeliness and accuracy of data.
• Revised activity #4 and added new activity #5 since we are on track to start on 2009 birth data and it is more timely to produce prevalence rates for the 2009 birth cohort.
• Revised #6 to be more accurate.

1. Monitor hospital reporting for completeness and timeliness.
2. Enhance OCCSN system to import data directly from reporters.
3. Compare OCCSN data with Medicaid.
4. Finalize 2008 prevalence rates for chromosome disorders.
5. Begin producing prevalence rates for the 2009 birth cohort on targeted birth defects.
6. Monitor referrals to services.
7. Promote Birth Defects Prevention Awareness Month.

Progress Report:

• Hospitals are monitored monthly, and a beta test is currently underway with hospitals for the direct data import.
• Prevalence rates for chromosome disorders are nearly complete.
• Work on 2009 prevalence rates has begun. Following an evaluation call with genetic counselors, new procedures are underway that will free up ODH staff time to make more referrals.
• Plans for Birth Defects Prevention Month (Jan. 2013) are underway.

**c. Plan for the Coming Year**

Maintain/enhance the Ohio Connections for children with Special Needs (OCCSN) birth defects information system to improve the utilization of data for surveillance, referrals to services and prevention activities.

1. Release report with 2008 prevalence rates.
2. Increase participation in infant mortality initiatives.
3. Finalize prevalence rates for 2009.
4. Promote Birth Defects Awareness Month.

**State Performance Measure 10:** *Increase the percent of children who receive timely, age-appropriate screening and referral.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 8 |
| Annual Indicator | | | | 12.5 | 25.0 |
| Numerator | | | | 1 | 2 |
| Denominator | | | | 8 | 8 |
| Data Source | | | | TBD/STELLAR | TBD/STELLAR |
| Is the Data Provisional or Final? | | | | Final | Provisional |

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Annual Performance Objective | 8 | 8 | 8 | 8 | 8 |

**Notes - 2011**
Provisional 2011 data is based on final 2010.

**Notes - 2010**
Developmental, hearing & vision will research the capacity to capture screening/referral data. Potential sources:Medicaid Healthchek, Help Me Grow or quality improvement projects. The child care licensure or quality system may have the capacity to collectscreening/referral data. Lead data source is the Ohio Childhood Lead Poisoning Prevention (STELLAR) surveillance database.

An EPSDT barrier is bundled services so it is not possible to distinguish separate elements of the visit. Future source for vision screening data is to be determined by 8/31/2012 as a product of the Ohio pilot of the National Universal Vision Screening for Young Children Coordinating Centerl STELLAR is 20 years old & will be replaced by the Healthy Homes & Lead Poisoning Surveillance System (HHLPSS). HHLPSS is presently undergoing beta testing by program with deployment expected in the summer. HHLPSS is a real time web based surveillance system linking health & housing.

Met Benchmark 1, select targeted age group(s) for tracking of screening and referral. Lead will target one and two year old children. Developmental will target birth to children prior to school entry. Hearing and vision will target children three years old to children prior to school entry.

Met Benchmark 1, select targeted age group(s) for tracking of screening and referral. Lead will target one and two year old children. Developmental will target birth to children prior to school entry. Hearing and vision will target children three years old to children prior to school entry.

This process measure tracks progress towards meeting benchmarks. This is a process measure that will be measured by the extent to which 8 benchmarks are reached. The target was to reach benchmark 1, select targeted age group(s) for tracking of screening and referral.

**a. Last Year's Accomplishments**
This process measure and strategies are capacity-building to improve the percent of children who receive timely, age-appropriate screening and referral using quality improvement science methods.

Benchmark 1 out of 1 was completed as projected in FFY11. Benchmark 2 was completed ahead of projection. Benchmarks 3 and 4 were completed by developmental and lead; vision and hearing projected completion of these benchmarks in FFY12.

A. Identify targeted age group(s) for tracking of screening and referral data. This infrastructure activity will be measured by the targeted age group(s) being identified.

The entire workgroup met twice. Lead screening will target one and two year old children, developmental screening for children from birth prior to school entry and hearing and vision screening for children three years old to school entry.

B. Identify screening and referral data sources. This is an infrastructure activity. The workgroup will research the capacity to capture data for measuring increases in the percent of children receiving timely, age-appropriate screening and referral (developmental, hearing and vision). This will be measured by researching available data sources to measure the increases and identifying the sources.

Over 129,000 kindergarten children received hearing screening (2% referred) and vision screening (9% referred) in 08-09. 10-11 data are being analyzed. Ohio Coalition for the Universal Vision Screening of Young Children met three times and identified groups who screen and capture data and how data points are collected.

Newborn Infant Hearing is part of the National Initiative for Children's Healthcare Quality collaborative to identify issues related to loss to follow-up and to implement improved processes to reduce loss to follow-up, birth to 3.

Developmental screenings occur in Help Me Grow using the Ages and Stages Questionnaire (ASQ) and ASQ-SE (social-emotional). The Healthy Child Care Ohio project screened 3,774 children for vision with 20% referred due to failed screening or unable to test and 3,563 for hearing with 11% referred due to failed screening or unable to test. There were 23 ASQ trainings and 15 ASQ:SE trainings and multiple consultations. There were also three trainings and one consult on lead. Help Me Grow provides developmental screening to over 15,000 children each year using ASQ and ASQ:SE and 8,000 children are screened via ASQ in the statewide Home Visiting program. ODH coordinates a developmental screening project that identifies and trains physicians to incorporate developmental screenings into their family or pediatric practices. Over 900 physicians' offices have been trained, resulting in dramatic increase in the referrals to Early Intervention and other early childhood programs. Next year, focus shifts to social-emotional and training on a range of screenings for children birth-18.

C. Identify a mechanism to collect screening and referral data for tracking and analysis. This infrastructure activity is measured by researching mechanisms to collect screening and referral data for tracking and analysis and identifying the mechanism.

Help Me Grow screening data, including developmental, hearing and vision, is collected via Early Track (birth to 3). Newborn Infant Hearing Screening data is collected via HiTrack.

ODH has a Healthy People 2020 Action Project one-year grant. ODH supports statewide data collection of hearing and vision screening and referral data by building upon the Ohio statewide immunization management system, ImpactSIIS. Until now, no universal database existed to capture some types of screening data for children (e.g., vision) for all ages. This serves as a potential mechanism for tracking and analysis.

Per STELLAR, approximately 112,000 children under 3 years of age were tested for lead in Ohio in FFY11. The Ohio Healthy Homes and Childhood Lead Poisoning Prevention Program seeks to improve lead test data collection and tracking of patients by implementing a new surveillance system, Healthy Homes and Lead Poisoning Prevention System (HHLPPS), beginning in FFY11 and completed by FFY12 year end. Staff is exploring the use of Ohio's immunization system, ImpactSIIS, to identify labs that are not reporting all blood lead levels as required by state law.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Identify targeted age group(s) for tracking of screening and referral data. | | | | X |
| 2. Identify screening and referral data sources. | | | | X |
| 3. Identify a mechanism to collect screening and referral data for tracking and analysis. | | | | X |
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| 5. | | | | |

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**b. Current Activities**
The SPM 10 workgroup continues to work on the strategies identified in the application in the Plan for the Coming
Year; the workgroup is making great progress towards meeting the identified benchmarks.

**c. Plan for the Coming Year**
Increase the percent of children who receive timely, age-appropriate screening and referral.

This is a process measure and strategies are primarily capacity-building to develop a statewide capacity to improve the percent of children who receive timely, age-appropriate screening and referral using quality improvement science methods.

A. Identify screening and referral data sources. This is an infrastructure activity. The workgroup will research the capacity to capture data for measuring increases in the percent of children receiving timely, age-appropriate screening and referral (developmental, hearing and vision). This will be measured by workgroup members researching available data sources to measure the increases and identifying the sources. Once the data sources are identified then the workgroup can identify the mechanism to collect the data.

B. Identify a mechanism to collect screening and referral data for tracking and a process for data transfer to the Ohio Department of Health (ODH) for analysis. This is an infrastructure activity. This is measured by the workgroup members researching mechanisms to collect screening and referral data for tracking and analysis and identifying the mechanism to transmit the data to ODH. Once indentified then the workgroup can identify the baseline data to track and monitor increases in the percent of children who receive timely, age-appropriate screening and referral.

C. Develop a screening and referral data analysis plan. This is an infrastructure activity. This is measured by the workgroup members developing a plan to analyze the screening and referral data. Once the plan is developed then the workgroup can monitor increases in the percent of children who receive timely, age-appropriate screening and referral.

## E. Health Status Indicators
In light of the new guidance from HRSA which indicates States may select one, some, or all health status indicators to discuss in the narrative section Ohio selected the HSI's below. These particular indicators were choosen primarily because they relate to MCH block grant activity that ODH have determined to be priority. The selections were made through a two-step process.

First, indicators with direct relevance to a state or national performance measure were identified. From those, indicators related to one of the 9 identified block grant priorities or the statewide efforts of the Ohio Collaborative to Prevent Infant Mortality (i.e., HSCI 04, HSI 01 A&B, and HSI 02A&B).

Health Status Indicator 01A: The percent of live birth weights less than 2,500 grams
Data Narrative
From the Vital Statistics Birth Records 8.6 percent of Ohio births in 2010 had a birth weight less than 2500 grams. This rate has been consistent within 0.3 percent since 2006 and shows no sign of decline. While not drastically different from the Health People 2020 goal of 7.8 percent, Ohio still has some room for improvement.

The average age of the mothers of these low birth weight (LBW) infants was 27 years. Mothers of singleton LBW infants were significantly younger than mothers of twins with LBW with a mean age of 26 and 29 respectively (p-value <0.0001). This may be indicative of older mothers utilizing artificial reproductive technology that increases the likelihood of multiple births.

Black mothers were 1.9 times more likely to have a low birth weight infant with 14 percent of all black births in 2010 being LBW versus 7.5 percent of white births. Hispanic infants were 0.9 times less likely to be of low birth weight than Non-Hispanic infants.

Medicaid recipients were 1.4 times more likely to have a low birth weight infant with 10.5 percent of births versus 7.5 percent weighing less than 2500 grams.

57.6 percent of multiple births were of low birth weight while only 6.8 percent of singleton births were of LBW. There a significant increase in low birth weight when plurality increases above 2 with 55.5 percent of twins having LBW and 93.6 percent of triplets and 95.3 percent of quadruplets being of low birth weight.

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Health Status Indicator 01B: The percent of singleton live birth weights less than 2,500 grams
Data Narrative
Vital Statistics Birth Records indicate that in 2010 6.7 percent of all singleton births were of low birth weight, less than 2,500 grams. This has been a relatively steady rate since 2006 with a peak of 7.0 percent and the low occurring in 2010. The slight decline since 2006 is an encouraging trend that interventions and education to prevent low birth weight (LBW) prevalence.

The average age of mothers giving birth to LBW babies is 26 years and a statistically significant difference from the age of mothers with normal birth weight babies (p-value <0.0001). White mothers of LBW infants had an average age of 27 years which significantly varied from black mothers with a mean age of 25 and p value <0.0001. Black mothers are also 2.2 times more likely to have a low birth weight infant with 12.1 percent of singleton black births weighing less than 2500 grams. Hispanic mothers are less likely to have a LBW infant with 6.1 percent of Hispanic births versus 6.8 percent of Non-Hispanic births being LBW.

Singleton births covered by Medicaid were 1.7 times more likely to be of LBW than non-Medicaid births with 9.0 percent of Medicaid births being of LBW.

Gestational age and birth weight are clinically linked and this relationship is reflected in the Ohio LBW gestational age distribution. LBW infants had a mean gestational age of 34 weeks compared to a mean age of 39 weeks for normal birth weight with a p-value <0.0001. NCHS defines preterm births as those occurring prior to 37 weeks. 75.0 percent of low birth weight births in Ohio in 2010 were preterm.

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Health Status Indicator 02A: The percent of live birth weights less than 1,500 grams
Data Narrative
2010 Ohio Vital Statistics Birth Records indicate that 1.7 percent of births were to infants that weighed less than 1500 grams, classified as very low birth weight (VLBW). This rate has been consistent over the past 5 years within 0.1 percent. Ohio's rate in 2010 was slightly above the

Healthy People 2020 goal of 1.4 percent of all births being of VLBW.
The mean age of mothers giving birth to VLBW infants was 27 years. Older and younger mothers had higher rates of VLBW births than those of intermediate ages, (2.9 percent of mothers < 15 years, 2.0 percent of 15-17 year old mothers, 1.9 percent of 18-19 year old mothers 1.7 percent of 20-24 year old mothers, 25-34 year old mother having only 1.6 percent of VLBW births, 1.9 percent of mothers aged 35-44, and 4.8 percent of mothers over the age of 45).

There was a significant difference in the age of black versus white mothers ( p-value <0.0001) in which black mothers were on average of two years younger than white. Racial disparities extended to the rates of VLBW births with black mothers being 2.4 times more likely to have an infant less than 1,500 grams ( 3.4 percent of black births versus 1.4 percent of white births). Hispanics had lower the rates of VLBW with only 1.5 percent of Hispanics versus 1.7 percent of Non-Hispanics delivering VLBW infants.

Births paid for by Medicaid were 1.3 percent more likely to be of VLBW than births having other methods of payment.
Multiple births are a major contributing factor to the likelihood of very low birth weight births. 12.7 percent of multiple births were VLBW versus only 1.3 percent of singleton births. Twins were 8.5 times more likely to be VLBW than a singleton births.

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Health Status Indicator 02B: The percent of live singleton birth weights less than 1,500 grams
Data Narrative
According to 2010 Ohio Vital Statistics 1.3 percent of singleton births weigh less than 1,500 grams. This rate has fluctuated between 1.2 and 1.3 percent for the past 5 years showing no changes in the trend. This small proportion of births are a public health concern because of their high rate of complications and death. In 2009 Ohio VLBW infants had a 30.4 percent neonatal mortality rate.

A racial disparity exists between white and black mothers with black mothers being 2.8 times more likely to have a VLBW infant than white. Hispanic mothers are 1.1 times less likely to have a VLBW birth than Non-Hispanic mothers.
Births paid for by Medicaid were 1.7 times more likely to be VLBW than non-Medicaid births.

Gestational age is differs significantly between infants weight less than 1,500 grams and those weighing more with mean gestational age of VLBW infants of 27.9 weeks versus 38.8 weeks for non-VLBW infants with a p-value <0.0001. 93.6 percent of VLBW infants were born prior to 37 weeks gestational age and considered preterm.

***An attachment is included in this section. IVE - Health Status Indicators***

## F. Other Program Activities

/2012/Title V Help Line
A. Since February/1995, DFCHS has operated the Help Me Grow (HMG) helpline, a statewide toll-free 800 number, which provides health and social service referrals and information to callers and is also the toll-free number for Title V programs. Information on programs from the following state agencies is currently available: ODE; ODH; ODJFS; ODMH; and ODMR/DD, as well as local sites for clinical services. The goal of the helpline is to allow for a single, clearly identifiable point of contact to obtain information on state programs and agencies serving families and children.

While ODH continues to market and advertise for the help line other state agencies have discontinued their marketing of this service. Some state and local programs have stopped putting the MCH Helpline number on their materials because they have created their own Hotlines and Helplines. ODH feels this has resulted in a decrease in the number of calls received by the HMG

Helpline. In FY2006 54,951 calls were received; in FY2007 41,088 calls were received; in FY2008 36, 624 calls were received. So there has been a steady decline in the number of calls.

Although there may be a decrease in overall calls ODH believes this service is very beneficial and at times critical to the MCH population. Of the total calls received 10,857 of the calls were transfered to BCMH and resulted in services and/or information being provided to CSHCN consumers or family members. HMG helpline is also collaborating with the Incident Command System to handle incident related calls. The helpline is prepared to take these calls 24 hours a day, 7 days a week and has developed a plan to quickly prepare and respond to calls.

B. Through its BCMH Office, ODH has partnered with and receives major support from consumer and family organizations across the state like the Family to Family Centers:(in collaboration with Family Voices):

Because Ohio is a home rule state with most services administered and delivered on a county basis, Family Voices of Ohio has chosen to support a family to family network, Family to Family Health Information Network(F2FHIN) rather than a single center to provide information, education and peer support to families of CSHCN throughout Ohio. The premise of this initiative is for parent health information specialists (HIS) to be housed in parent organizations throughout the state.

Family Voices of Ohio has established four parent HIS in parent organizations located in four regions of the state. These organizations are: Family Information Network of Toledo (NW Ohio), Parent Coalition for Persons with Disabilities in Akron (NE Ohio), the Early Childhood Resource Network in Columbus (Central Ohio), and Ohio Brain Injury Association (SE Ohio). A fifth organization, The Collaborative of NW Ohio, will serve as fiscal agent for FV of Ohio. These parent organizations have been dedicated to serving all disabilities and diagnoses for many years and have worked closely with other family serving agencies, and are familiar with the cultural and ethnic needs of surrounding communities.

Family Voices of Ohio in collaboration with the designated parent organizations and the BCMH program, identifies and has contracted with parents who are experienced in the complexities of the health care system. These centers are located so that families of CSHCN throughout Ohio are served within their communities.

Parent navigators in each region: 1) partner with the 211 agencies of the surrounding area including the use of interpreter services, 2) work in conjunction with service coordinators from Help Me Grow, BCMH public health nurses, MR/DDs, mental health agencies, and children's hospitals, 3) connect with family support and advocacy organizations, 4) network with local AAP chapters, 5) arrange for trainings in collaboration with BCMH and Family Voices, 6) collaborate with local Benefits Bank counselors to enroll families in public programs like Medicaid, 7) identify and assist cultural groups to address their children's health disparities, 8) and report data regularly.

A key component of Ohio's Family to Family Health Information Network is to initiate and maintain a partnership with Ohio's Title V program, the Bureau for Children with Medical Handicaps. See the attached re

Attached for review is Ohio's Family and Children First Council report on Youth and Young Adults in Transition Steering Committee Strategic Planning Report that addresses the needs of youth including, transition services, housing, college and job placement. The Young Adult Advisory Committee (YAAC) composed of youths aged 16 to 24 who are receiving or have received BCMH services, advise BCMH of issues facing youth as they transition into adult medical and social services, the Parent Advisory Committee (PAC) composed of parents from around the state who meet regularly to advise BCMH regarding care for children with special health care needs, as well as BCMH staff were instrumental in the development of this plan. //2012//

***/2013/ The BCMHEI Office continues to engage with community stakeholder around the needs for CYSHCN. Ohio's CYSHCN program is partnering with "REAL Action in Ohio: Resources, Education, Alignment and Linkages", the HRSA State Implementation Grant for Autism and Related Developmental Disabilities which was awarded to the Ohio Department of Developmental Disabilities. Additional key partners on this work include Ohio's Center for Autism and Low Incidence (OCALI), the Family Child Learning Center (FCLC) at Akron Children's Hospital, Ohio's two UCEDD/LEND programs housed at the Nisonger Center (OSU) and Cincinnati Children's/University of Cincinnati as well as Ohio's Interagency Workgroup on Autism. Additional collaboration can be found in the attached Nisonger Announcement which is attached. //2013//***
***An attachment is included in this section. IVF - Other Program Activities***

## G. Technical Assistance

Technical Assistance Requests (not listed in order of preference or importance):

1. State Performance Measure 04 Issues
Description of Technical Assistance Requested:
Ohio's DFCHS is requesting a multiple- days train-the-trainers cultural and linguistic competence workshop to ensure continuous and uniform site training to staff and local grantees; and give "how to's" for assessing related intervention outcomes.

Reason(s) Why Assistance is Needed:
To expand DFCHS's capacity to reduce health disparities in health outcomes through the delivery of services which are culturally and linguistically competent. Only 10 of 44 DFCHS programs now provide cultural and linguistic competence training.

What State, Organization or Individual Would You Suggest Provide the TA:
We are requesting Technical assistance from the National Center for Cultural Competence.

2. Fetal Infant Mortality Review (FIMR)
Description of Technical Assistance Requested:
Training for local and/or state teams on the development of FIMR programs to analyze factors contributing to fetal and infant death.

Reason(s) Why Assistance is Needed:
Ohio currently does not have the expertise at the state level to provide guidance to local agencies. We would like to be able to provide training to local teams so they can compile and analyze FIMR data.

What State, Organization or Individual Would You Suggest Provide the TA:
The Michigan Department of Community Health has experience in training and supporting local as well as state FIMR teams.

3. State Performance Measure 06
Description of Technical Assistance Requested:
Assistance with the development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and training on how to use these indicators to evaluate preconception health effects.

Reason(s) Why Assistance is Needed:
Ohio has identified the development of a core set of preconception health indicators as a state

performance measure. We would like to use the experience of other states that have already developed a list of indicators.

What State, Organization or Individual Would You Suggest Provide the TA:
Representatives from the multi-state consortium who worked to identify a core list of preconception health indicators.

4. State Performance Measure 02
Description of Technical Assistance Requested:
Assistance with the development and implementation of a social marketing campaign specifically targeted to those highest at risk for poor birth outcomes. This proposal seeks to design relevant and motivational pre-conception and inter-conception messages and their content. Both the messages and their delivery system will be based on market research of different segments of the priority population.

Reason(s) Why Assistance is Needed:
Preconception care has been identified as the area with the most potential to improve birth outcomes. Ohio's IMR of 7.8 (2006)[2], after steadily decreasing for years, has not substantially changed for more than a decade. Ohio's African-American infants die at more than twice the rate of white infants. The IMR in Ohio is the twelfth-highest in the country[3] and exceeds the national goal of 4.5 established by the DHHS in the Healthy People 2010 initiative.

5. MCH Cost Analysis
Description of Technical Assistance Requested:
Development of a comprehensive MCH cost analysis program that can be used by local subgrantees to analyze the cost of providing MCH services at all levels of the pyramid. This will assist both the local subgrantees and ODH in making the most cost effective use of limited MCHBG funds.

Reason(s) Why Assistance is Needed:
With cuts to state and federal grant programs, MCH public health services are being widely curtailed. It is essential to make the best use of all available funds.

What State, Organization or Individual Would You Suggest Provide the TA:
George H.W. "Gerry" Christie
Health Policy Analysts
114 Dewberry Lane
Syracuse, NY 13219
ghchristie@worldnet.att.net

/2012/ 1. State Performance Measure 04
Assistance is required to develop a cultural and linguistic competency Fidelity Tool Kit, for use by ODH MCH Title V staff and its grantees.

Reason(s) Why Assistance is Needed:
Expert knowledge is required to provide a Fidelity Tool Kit comprised of references and documentation on guidance and tools establishing standards and criteria for implementing, monitoring and evaluating cultural and linguistic progress.

What State, Organization or Individual Would You Suggest Provide the TA:
Performance Consulting Services (Ohio based)

2. National Performance Measure 14:
Ohio staff needs to learn how to clean and analyze their WIC data in order to recreate the PedNSS files and data reports received annually from CDC.

Reason(s) Why Assistance is Needed:
Ohio contributes to the CDC's Pediatric Nutrition Surveillance System (PedNSS) and uses the cleaned and analyzed data from this system to report on NPM#14. Ohio was informed that PedNSS reports will no longer be issued from CDC after 2011.

What State Organization or Individual Would You Suggest Provide the TA:
CDC Division of Nutrition Physical Activity and Obesity (which has run the PedNSS system)
//2012//

# V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **1. Federal Allocation** *(Line1, Form 2)* | 22118275 | 17875553 | 17909748 | | 21376000 | |
| **2. Unobligated Balance** *(Line2, Form 2)* | 3419327 | 3419327 | 2498838 | | 4014636 | |
| **3. State Funds** *(Line3, Form 2)* | 31175158 | 37321233 | 34712622 | | 28670920 | |
| **4. Local MCH Funds** *(Line4, Form 2)* | 0 | 0 | 0 | | 0 | |
| **5. Other Funds** *(Line5, Form 2)* | 12324474 | 12599074 | 44105176 | | 51255819 | |
| **6. Program Income** *(Line6, Form 2)* | 0 | 0 | 0 | | 0 | |
| **7. Subtotal** | 69037234 | 71215187 | 99226384 | | 105317375 | |
| **8. Other Federal Funds** *(Line10, Form 2)* | 321146370 | 267391754 | 279684531 | | 221887656 | |
| **9. Total** *(Line11, Form 2)* | 390183604 | 338606941 | 378910915 | | 327205031 | |

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| **I. Federal-State MCH Block Grant Partnership** | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **a. Pregnant Women** | 7428657 | 7380366 | 14637399 | | 14836468 | |
| **b. Infants < 1 year old** | 3242168 | 3221092 | 6388356 | | 17521162 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **c. Children 1 to 22 years old** | 20806533 | 20671279 | 40997122 | | 38292216 | |
| **d. Children with Special Healthcare Needs** | 37002105 | 39317924 | 36550989 | | 33777722 | |
| **e. Others** | 0 | 0 | 0 | | 0 | |
| **f. Administration** | 557771 | 624526 | 652518 | | 889807 | |
| **g. SUBTOTAL** | 69037234 | 71215187 | 99226384 | | 105317375 | |
| **II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).** | | | | | | |
| **a. SPRANS** | 0 | | 0 | | 0 | |
| **b. SSDI** | 94644 | | 130915 | | 0 | |
| **c. CISS** | 0 | | 0 | | 0 | |
| **d. Abstinence Education** | 0 | | 0 | | 1912235 | |
| **e. Healthy Start** | 0 | | 0 | | 0 | |
| **f. EMSC** | 0 | | 0 | | 0 | |
| **g. WIC** | 279937903 | | 250000000 | | 190855056 | |
| **h. AIDS** | 0 | | 0 | | 0 | |
| **i. CDC** | 1314917 | | 600000 | | 0 | |
| **j. Education** | 14497916 | | 14617867 | | 14296808 | |
| **k. Home Visiting** | 0 | | 0 | | 4252919 | |
| **k. Other** | | | | | | |
| **Black Lung** | 0 | | 607000 | | 660894 | |
| **CDC Birth Defects** | 0 | | 0 | | 179999 | |
| **LAUNCH** | 0 | | 850000 | | 850000 | |
| **New Born Hearing** | 0 | | 300000 | | 300000 | |
| **Other Funds** | 0 | | 0 | | 2566520 | |
| **PREP** | 0 | | 1916033 | | 1912576 | |
| **Primary** | 0 | | 0 | | 331672 | |
| **Rural Health** | 167200 | | 0 | | 180000 | |
| **Title X** | 0 | | 0 | | 3538977 | |
| **Youth Risk Behaviors** | 0 | | 50000 | | 50000 | |
| **Home Visiting** | 0 | | 3194214 | | 0 | |
| **Other funds see note** | 0 | | 2843426 | | 0 | |
| **Primary** | 0 | | 275000 | | 0 | |
| **Rural Health** | 0 | | 131498 | | 0 | |
| **Title X** | 0 | | 4168578 | | 0 | |
| **BlacK Lung** | 291000 | | 0 | | 0 | |
| **Family Planning** | 4251624 | | 0 | | 0 | |
| **Nat'L Student Loans** | 440000 | | 0 | | 0 | |
| **New Born Hearing** | 150000 | | 0 | | 0 | |
| **Other Funds-see note** | 18649633 | | 0 | | 0 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **PRAMS** | 146951 | | 0 | | 0 | |
| **Primary Care** | 312662 | | 0 | | 0 | |
| **Rural Flex** | 591600 | | 0 | | 0 | |
| **SRHIP** | 300320 | | 0 | | 0 | |

### Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| **I. Direct Health Care Services** | 37988021 | 41656104 | 37081261 | | 68817605 | |
| **II. Enabling Services** | 12352619 | 11769726 | 14622433 | | 4956759 | |
| **III. Population-Based Services** | 6702317 | 6379012 | 3655392 | | 2253072 | |
| **IV. Infrastructure Building Services** | 11994277 | 11410345 | 43867298 | | 29289939 | |
| **V. Federal-State Title V Block Grant Partnership Total** | 69037234 | 71215187 | 99226384 | | 105317375 | |

## A. Expenditures

A. Expenditures

Form 3 -- FFY09

• Ohio will use the un-obligated balance to support MCH activities during the first quarter of the new federal fiscal year until the arrival of the new notice of award.

• The FFY09 Federal-State Title V Block Grant Partnership expenditures were $66,002,024. This is $2,375,257 above the FFY08 expenditures of $63,626,767.

• Overall FFY09 expenditures (including other federal funds) related to MCH activities were $372,313,299. This is $4,422,956 below the FFY08 expenditures of $376,736,255.

Form 4 -- FFY09

• FFY09 expenditures for: pregnant women at $6,869,910; infants at $2,998,308; and children (1-22) at $19,241,569. These are all below the FFY08 expenditure levels for each category.

• FFY 09 expenditures for children with special health care needs of $36,244,849 are above the FFY08 amount of $32,749,927 by $3,494,922.

• The FFY09 administration expenditures were $647,388. This is $248,166 above the FFY 08 expenditures of $399,222. The increase in administrative costs is due to the filling of vacant positions. At 2.9% of total MCH-BG expenditures, the administration costs are well within the 10 percent restriction requirement.

Form 5 -- FFY09
• FFY09 expenditures for: Direct Health Care Services - $36,503,996; Enabling Services - $11,736,206; Population Based Services - $6,367,359; and, Infrastructure Building Services of $11,394,463 are 55.3 percent, 17.8 percent, 9.6 percent, and 17.3 percent of total Federal-State Title V Block Grant Partnership expenditures, respectively.

/2012/ A. Expenditures

Form 3 -- FFY10
• Ohio will use the un-obligated balance to support MCH activities during the first quarter of the new federal fiscal year until the arrival of the new notice of award.

• The FFY10 Federal-State Title V Block Grant Partnership expenditures were $67,605,787. This is $1,603,763 above the FFY09 expenditures of $66,002,024.

• Overall FFY10 expenditures (including other federal funds) related to MCH activities were $349,307,018, this is $23,006,281 below the FFY09 expenditures of $372,313,299.

Form 4 -- FFY10
• FFY10 expenditures for: pregnant women at $6,990,721; infants at $3,305,035; and children (1-22) at $19,579,944. These are all above the FFY09 expenditure levels for each category.

• FFY 10 expenditures for children with special health care needs of $37,442,582 are above the FFY09 amount of $36,244,849.

• The FFY10 administration expenditures were $541,505. This is $105,883 below the FFY 09 expenditures of $ 647,388.

Form 5 -- FFY10

• FFY10 expenditures for: Direct Health Care Services - $39,625,177; Enabling Services - $11,132,378; Population Based Services - $6,039,830; and, Infrastructure Building Services of $10,808,402 are 58.6 percent, 16.5 percent, 8.9 percent, and 16.0 percent of total Federal-State Title V Block Grant Partnership expenditures, respectively. //2012//

***/2013/ In review of Ohio's Budget details and the information submitted for SFY2012 you will note changes in the amount expended by "individuals served" as well as by "types of services". Ohio would like to provide feedback in regards to the methodology used for this BG application report. The methodology used to determine the amount budgeted for the four levels of the MCH pyramid changed.***

***Previously the MCH Partnership Funds used to support Component C were defined as direct services and set aside. The balance of the Partnership Funds was then divided among the four levels by using the ratios for the levels as determined by the CFHS sub-grant program. The Component C funds were added to direct service share of the balance of the Partnership funds to determine the total direct service share of the Partnership Funds. However due to the success of the CFHS Program in reducing the direct service share of its' sub-grant programs, this method can no longer be applied to the non BCMH portion of the Partnership funds.***

***As of the FFY 13 application a new approach was used. Under the new approach each source of Partnership funds was designated as "direct" or "non-direct funds." Those funds designated as direct will be set-aside, while the balance will be subject to the CFHS***

***ratios. The direct share of the balance will be added to the "designated direct" funds for the total amount of direct funds. The application of the CFHS ratios will then yield the amount of support for the other three levels of the pyramid. Although this methodology was used, after further discussion Ohio has determined that we will further review the methodology and outline a set methodology that will be used with in future BG application submissions.***

***In addition, to the above Ohio also determined that $33 million dollars allocated for Help Me Grow was initially earmarked and classified as direct service dollars, However after further review of the community services provided by these dollars Ohio determined that it would be more appropriate to classify them as enabling. The shift in this allocation of funding from "direct care services" to "enabling services" will further balance the level of funding among the pyramid "types of services". //2013//***

## B. Budget

B. Budget

In light of the limited and often reduced funding at both the state and federal levels, ODH is committed to directing its available resources towards the funding of essential planned programs that address the state's priorities. Maternal Child Health Title V Block Grant funding is essential to ODHs' ability to support its MCH programs and address those priorities. During the planning for the five year needs assessment, Ohio was afforded the opportunity to engage a new compliment of people, examine its data information in new ways, and thoughtfully plan how it will link resources with MCH programs given the changing landscape in Ohio.

Examples of how Ohio has redirected its precious MCH Block Grant resources to address the priorities that resulted from this needs assessment and planning process include: the redirection of the Regional Perinatal Coordinator program to perinatal quality improvement initiative; the shift from a focused lead poisoning prevention programs to a broader healthy homes initiative; and Ohio is also capitalizing on several other funding opportunities, primarily from HRSA, to augment the investment in addressing these very important priorities for our state.

While most block grant funding is for continuing MCH programs and activities, some of the funding is being used for developmental/new projects. The expectation is that those projects will evolve into operational entities or have completed their original purpose in keeping with their stated goals. This funding approach allows continuation funds to be used to begin new innovative projects that align with the state priorities.

3.3 Annual Budget and Budget Justification

Summary Budget Description for FY2011

- Component A: Services for Pregnant Women, Mothers and Infants up to age one year
- Component B: Preventive and Primary Care Services for Children and Adolescents
- Component C: Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care needs and their families.

o Component A: $3,700,349
o Component B: $ 10,634,073
o Component C: $ 7,225,952
o Subtotal: $21,560,374
o Administrative Costs: $ 557,901
o GRANT TOTAL: $22,118,275.

* Administrative costs are applied proportionally to Components A, B and C.

Budget Justification

- Services for Pregnant Women, Mothers and Infants to Age One
  - In its FFY 2011 request, Ohio has budgeted $92,711,621 for services for Pregnant Women, Mothers and Infants to Age One; 23.76 percent of the total funds ($390,183,604) targeted for Title V related activities. For this component, MCH Block Grant funds total $3,700,349 which is 16.73 percent of the FFY 11 MCH Block Grant request of $22,118,275. Other State and Federal funds for this component total $89,011,272 or 24.18 percent of the budgeted $368,065,329 in other Title V related funds.

- Preventive and Primary Care Services for Children and Adolescents
  - In its FFY2011 request, Ohio has budgeted $255,744,414 for Preventive and Primary Care Services for Children and Adolescents or 65.54 percent of the total funds ($390,183,604) designated for Title V and related activities. For this component, MCH Block Grant funds total $10,634,073 which is 48.08 percent of the FFY 11 MCH Block Grant request of $22,118,275. Other State and Federal funds for this component total $245,110,341 which is 66.59 percent of the $368,065,329 of other Title V related funds.

- Children with Special Health Care Needs
  - In its FFY2011 request, Ohio has budgeted $41,083,420 for activities for Children with Special Health Care Needs or 10.53 percent of the percent of the total funds ($390,183,604) budgeted for Title V and related activities. For this component, MCH Block Grant funds total $7,225,952 which is 32.67 percent of the FFY 11 MCH Block Grant request of $22,118,275. Other State funds for CSHCN total $33,857,468 which is 9.2 percent of the $368,065,329 of other Title V related funds.

- Administrative Costs
  - $557,901 or 2.52 percent of the requested FFY 11 MCH BG funds.

- Maintenance of State Effort
  - In 1989, Ohio's MCH Block Grant award was $19,369,474 and the state provided $23,812,983 in support of the MCH activities. The fiscal year 2011 federal MCH award is expected to be $22,118,275 and the state will provide $33,191,474. State support is provided by appropriations from several state line items and one source of county funds which the Division is authorized to spend on behalf of children with special health care needs. The particular line items and their level of funding in 1989 and 2010 are shown below:

| Description | 1989 | 2010 |
|---|---|---|
| Sickle Cell Control | $421,347 | $1,035,344 |
| Genetic Services | $1,144,281 | $918,227 |
| Child & Family Health Services | $5,652,423 | $4,338,449 |
| Adolescent Pregnancy | $400,000 | $0 |
| Medically Handicapped Children | $4,682,744 | $8,762,451 |
| Cystic Fibrosis | $325,394 | $0 |
| Medically Handicapped Audit Funds | $1,312,168 | $3,693,016 |
| Medically Handicapped County Funds | $9,874,626 | $17,320,687 |

| | | |
|---|---|---|
| Totals | $23,812,983 | $36,068,174 |

To determine the total amount of state match and funding of MCH programs, the Division of Family and Community Health Services (DFCHS) totals several of the state appropriation line items which are dedicated to Title V related activities. The authorization levels of the line items are determined by the State Legislature as part of the biennial budget process, but actual expenditures may depend upon executive order reductions, reimbursement limits and revenue limitations.

The above Maintenance of Effort chart lists the 2011 state appropriations as outlined in the appropriations bill. The cystic fibrosis appropriation line item is no longer shown as match/maintenance of effort because they are dedicated to the provision of services to adults. Services for children with cystic fibrosis are supported by other state CSHCN funds.
One million, two hundred thousand dollars ($1,200,000) of the state Child and Family Health Services appropriation is not included as match for the Title V award because it is designated as part of a state initiative called Women's Health (previously dedicated to family planning services).

An additional $2,686,688 of General Revenue Funds are set-aside for Federally Qualified Health Centers (FQHSs) and are not included on Form 424, Line 15c as match to Title V funds. These funds are included in Line 15e because the population to be served is broader than the population served by MCH funds.

Ohio's maintenance of effort has decreased by $2,974,561 from $39,042,735 in 2010 to $36,068,174 in 2010. The major reason for this decrease in funding for the Child and Family Health Services is due to the states General Revenue Funds (GRF) line item. Ohio continues to experience a drop in expected revenue receipts. This continues to have an impact on the amount of GRF available to support MCH and other state initiatives.

In CY 07, The Ohio Department of Health received the first reimbursement under the Medical Administrative Claiming program (MAC). To date, 33 counties have established the MAC program at the local level. The department continues to encourage the expansion of the MAC program at the local level as a means of off-setting decreasing state revenues. Funds earned under this program are being used by the department and local health departments to support Title V activities.

Rate Agreement
- STATE AND LOCAL DEPARTMENT/AGENCIES
- EIN NO: 1-316402047-A1
- DEPARTMENT/AGENCY: Ohio Department of Health Date: September 18, 2007

246 North High Street
P.O. Box 118 FILING REF: The preceding
Columbus, Ohio 43266-0118 Agreement was dated 9/25/07

- The rates approved in this Agreement are for use on grants, contracts and other agreements with the Federal Government subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

| Type | From | To | Rate | Locations | Applicable to |
|---|---|---|---|---|---|
| Prov. | 7/1/09 | 6/30/10 | 30.5% | On Site | Unrestricted (1) |
| Fixed | 7/1/10 | Until Amended | 33.1% | On Site | Unrestricted (1) |

Fixed 7/1/10 6/30/11 15.1% On Site Restricted (2)

Fixed 7/1/06 6/30/07 15.1% On Site Restricted (1)

*Restricted rate is for U.S. Department of Education Programs which requires the use of a restricted rate as defined by 34 CFR Parts 75.563 & 76.563.
1) Base -- Direct salaries and wages including all fringe benefits.
2) Base -- Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations, sub-awards and flow-through funds).

Administrative Costs
• The administrative costs of Ohio's 2011 MCH Block Grant request are based on budget and expenditures related to the Operational Support Section of the Division Chief's office. The Operational Support Section is responsible for administrative activities (e.g., grant processing, purchasing, personnel, etc.) associated with MCH and MCH related programs.

FFY2010 Carry Over Funds
• The amount of carryover funds is based on the total amount of funds available in FFY 2010 less projected expenditures through September 30, 2010. In FFY2010 a total of $25,433,765 in MCH Block Grant funds were available to the State of Ohio. According to the State's accounting reports, which reflect activity through May 19, 2010, the projected FFY2009 MCH expenditures will total $22,014,438. When total available funds are reduced by total projected expenditures the unencumbered balance will be $3,419,449.

• The Ohio Maternal and Child Health Programs support the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to enable state MCH agencies to provide funding stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the projected lapsed amount is equal to approximately 1.5 months worth of its 1st quarter expenditures.

/2012/ See attached Narrative for FFY10 Budget Update. //2012//

***/2013/ A. Expenditures***

***Form 3 -- FFY11***

***Ohio will use the un-obligated balance to support MCH activities during the first quarter of the new federal fiscal year until the arrival of the new notice of award.***

***The FFY11 Federal-State Title V Block Grant Partnership expenditures were $71,215,188. This is $3,609,401 above the FFY10 expenditures of $ 67,605,787.***
***Overall FFY11 expenditures (including other federal funds) related to MCH activities were 338,606,942***
***This is $10,700,076 below the FFY10 expenditures of $349,307,018.***

***Form 4 -- FFY11***
***FFY11 expenditures for: pregnant women at $7,380,366; infants at $3,221,092; and children (1-22) at $20,671,271. Expenditures for pregnant women and children exceeded the FFY 10 levels. The expenditures for infants were less than the FFY 10 levels by $83,943.***

***FFY 11 expenditures for children with special health care needs were $39,317,926 or***

***$1,875,344
above the FFY10 amount of $37,442,582.***

***The FFY11 administration expenditures were $624,526. This is $83,021 above the FFY 10 expenditures of $541,505.***

***.
Form 5 -- FFY11***

***FFY11 expenditures for: Direct Health Care Services - $41,656,106; Enabling Services - $11,769,726; Population Based Services - $6,379,012; and, Infrastructure Building Services of
$11,410,345. These amounts represent 58.5 percent, 16.5 percent, 9.0 percent, and 16.0 percent of total Federal-State Title V Block Grant Partnership expenditures, respectively.***

***B. Budget***

***While most block grant funding is for continuing MCH programs and activities, some of the funding is being used for developmental/new projects. The expectation is that those projects will evolve into operational entities or have completed their original purpose in keeping with their stated goals. This funding approach allows continuation funds to be used to begin new innovative projects that align with the state priorities.***

***B. Budget***

***3.3 Annual Budget and Budget Justification***

***Summary Budget Description for FY2013***

***• Component A: Services for Pregnant Women, Mothers and Infants up to age one year
• Component B: Preventive and Primary Care Services for Children and Adolescents
• Component C: Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care needs
and their families.***

***Component A: $ 5,760,929
Component B: $ 8,217,341
Component C: $ 6,507,922
Subtotal: $20,486,192***

***Administrative Costs: $889,808***

***GRANT TOTAL: $21,376,000***

***Administrative costs are applied proportionally to Components A, B and C.***

***Budget Justification***

***Services for Pregnant Women, Mothers and Infants to Age One***

***In its FFY 2013 request, Ohio has budgeted $99,753,223 for services for Pregnant Women, Mothers and Infants to Age One; 30.49 percent of the total funds ($327,205,032) targeted for Title V related activities. For this component, MCH Block Grant funds total $5,760,929 which is 26.95 percent of the FFY 13 MCH Block Grant request of $21,376,000.***

Other State and Federal funds for this component total $93,992,294 or 30.73 percent of the budgeted amount of $305,829,032 in other Title V related funds.

**Preventive and Primary Care Services for Children and Adolescents**

In its FFY 2013 request, Ohio has budgeted $136,596,971 for Preventive and Primary Care Services for Children and Adolescents or 41.75 percent of the total funds ($327,205,032)
designated for Title V and related activities. For this component, MCH Block Grant funds total
$8,217,341 which is 38.44 percent of the FFY 13 MCH Block Grant request of $21,376,000. Other State and Federal funds for this component total $128,379,630 which is 41.98 percent of
the $305,829,032 of other Title V related funds.

**Children with Special Health Care Needs**

In its FFY 2013 request, Ohio has budgeted $89,797,915 for activities for Children with Special Health Care Needs or 27.44 percent of the percent of the total funds ($327,205,032) budgeted for Title V and related activities. For this component, MCH Block Grant funds total
$6,507,922 which is 30.44 percent of the FFY 13 MCH Block Grant request of $21,376,000. Other State funds for CSHCN total $83,289,993 which is 27.23 percent of the $305,829,032 of other
Title V related funds.

**Administrative Costs**

$889,808 or 4.16 percent of the requested FFY 13 MCH BG funds.

**Maintenance of State Effort**

In 1989, Ohio's MCH Block Grant award was $19,369,474 and the state provided $23,812,983 in support of the MCH activities. The fiscal year 2013 federal MCH award is expected to be $21,376,000 and the state will provide $39,516,649. State support is provided by appropriations from several state line items and one source of county funds which the Division is authorized to spend on behalf of children with special health care needs. The particular line items and their level of funding in 1989 and 2013 are shown below:

| Description | 1989 | 2013 |
|---|---|---|
| Sickle Cell Control | $421,347 | $1,032,824 |
| Genetic Services | $1,144,281 | $3,311,039 |
| Child & Family Health Services | $5,652,423 | $4,228,015 |
| Adolescent Pregnancy | $400,000 | $0 |
| Medically Handicapped Children | $4,682,744 | $7,512,451 |
| Cystic Fibrosis | $325,394 | $0 |
| Medically Handicapped Audit Funds | $1,312,168 | $3,692,703 |
| Medically Handicapped County Funds | $9,874,626 | $19,739,617 |
| Totals | $23,812,983 | $39,516,649 |

To determine the total amount of state match and funding of MCH programs, the Division

*of*
*Family and Community Health Services (DFCHS) totals several of the state appropriation line*
*items which are dedicated to Title V related activities. The authorization levels of the line items*
*are determined by the State Legislature as part of the biennial budget process, but actual expenditures may depend upon executive order reductions, reimbursement limits and revenue*
*limitations.*

*The above Maintenance of Effort chart lists the 2013 state appropriations as outlined in the appropriations bill. The cystic fibrosis appropriation line item is no longer shown as match or maintenance of effort because they are dedicated to the provision of services to adults.*
*Services for children with cystic fibrosis are supported by other state CSHCN funds.*

*In CY 07, The Ohio Department of Health received the first reimbursement under the Medical*
*Administrative Claiming program (MAC). To date, 48 counties have established the MAC program at the local level. The department continues to encourage the expansion of the MAC*
*program at the local level as a means of off-setting decreasing state revenues. Funds earned*
*under this program are being used by the department and local health departments to support*
*Title V activities.*

*Rate Agreement*

*• STATE AND LOCAL DEPARTMENT/AGENCIES*
*• EIN NO: 1-316402047-A1*
*• DEPARTMENT/AGENCY: Ohio Department of Health Date: July 6, 2009*
*246 North High Street*
*P.O. Box 118 FILING REF: The preceding*
*Columbus, Ohio 43266-0118 Agreement was dated 9/15/2011*
*• The rates approved in this Agreement are for use on grants, contracts and other agreements with the Federal Government subject to the conditions in Section III.*

*SECTION I: INDIRECT COST RATES*

| Type | From | To | Rate | Locations Applicable to |
|---|---|---|---|---|
| PRED. | 7/1/10 | 6/30/11 | 33.1% | On Site Unrestricted (1) |
| PRED. | 7/1/11 | 6/30/13 | 31.8% | On Site Unrestricted (1) |
| PRED. | 7/1/11 | 6/30/13 | 25.4% | On Site Restricted (1) |

*PROV. 7/1/13 Until Amended Use same rates and conditions as those cited for fiscal year ending June 30, 2001.*

**Restricted rate is for U.S. Department of Education Programs which requires the use of a restricted rate as defined by 34 CFR Parts 75.563 & 76.563.*
*1) Base -- Direct salaries and wages including all fringe benefits.*
*2) Base -- Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations, sub-awards and flow-through funds).*

*Administrative Costs*

***The administrative costs of Ohio's 2013 MCH Block Grant request are based on budget and expenditures related to the Operational Support Section of the Division Chief's office. The***
***Operational Support Section is responsible for administrative activities (e.g., grant processing,***
***purchasing, personnel, etc.) associated with MCH and MCH related programs.***

***FFY2012 Carry Over Funds***
***The amount of carryover funds is based on the total amount of funds available in FFY 2012 minus the projected expenditures through September 30, 2012. In FFY2012 a total of $22,674,982 in MCH Block Grant funds was available to the State of Ohio. According to the State's accounting reports, which reflect activity through June 6, 2012, the projected FFY2012***
***MCH expenditures will total $18,660,346. When total available funds are reduced by total projected expenditures the unencumbered balance will be $4,014,636.***

***The Ohio Maternal and Child Health Programs support the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to enable state MCH agencies to provide funding stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the projected lapsed amount is equal to approximately 1.5 months worth of its 1st quarter expenditures. //2013//***

## VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note

Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting documents

### A. Needs Assessment

Please refer to Section II attachments, if provided.

### B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.